

Future reviews of monitoring data will be conducted, in conjunction with the State of Iowa, at a minimum of every five years, or until such time when no hazardous substances, pollutants or contaminants remain at the site above levels that allow for unrestricted use and unlimited exposure.

The EPA identifies sites that appear to present a significant risk to public health, welfare, or the environment and maintains the NPL as the list of those sites. Sites on the NPL may be the subject of remedial actions financed by the Hazardous Substance Response Fund (Fund). Pursuant to section 105(e) of CERCLA, any site deleted from the NPL remains eligible for Fund-financed Remedial Actions if conditions at the site warrant such action. Deletion from the NPL does not affect responsible party liability or impede EPA efforts to recover costs associated with response efforts.

#### **List of Subjects in 40 CFR Part 300**

Environmental protection, Chemicals, Hazardous substances, Hazardous wastes, Superfund.

**Dennis Grams,**

*Regional Administrator.*

For the reasons set out in the preamble 40 CFR part 300 is amended as follows:

#### **PART 300—[AMENDED]**

1. The authority citation for part 300 continues to read as follows:

**Authority:** 42 U.S.C. 9601–9657; 33 U.S.C. 1321(c)(2); E.O. 12777, 56 FR 54757, 3 CFR, 1991 Comp., p. 351; E.O. 12580, 52 FR 2923, 3 CFR, 1987 Comp., p. 193.

#### **Appendix B—[Amended]**

2. Table 1 of appendix B to part 300 is amended by removing the Site “Northwestern States Portland Cement Company Superfund Site, Cerro Gordo, Iowa”.

[FR Doc. 95–21407 Filed 8–30–95; 8:45 am]

BILLING CODE 6560–50–P

## **DEPARTMENT OF HEALTH AND HUMAN SERVICES**

### **Health Care Financing Administration**

#### **42 CFR Parts 400 and 411**

[BPD–482–FC]

RIN 0938–AD73

#### **Medicare Program; Medicare Secondary Payer for Individuals Entitled to Medicare and Also Covered Under Group Health Plans**

**AGENCY:** Health Care Financing Administration (HCFA), HHS.

**ACTION:** Final rule with comment period.

**SUMMARY:** These regulations establish limits on Medicare payment for services furnished to individuals who are entitled to Medicare on the basis of disability and who are covered under large group health plans (LGHPs) by virtue of their own or a family member's current employment status with an employer; and prohibit LGHPs from taking into account that those individuals are entitled to Medicare on the basis of disability.

They also implement certain other provisions of section 1862(b) of the Social Security Act, as amended by the Omnibus Budget Reconciliation Acts of 1986, 1989, 1990, and 1993 and the Social Security Act Amendments of 1994. Those amendments affect the Medicare secondary payer rules for individuals who are entitled to Medicare on the basis of age or who are eligible or entitled on the basis of end stage renal disease and who are also covered under group health plans (GHPs). The provisions that apply to all three groups include—

- The rules under which HCFA determines that a GHP or LGHP is not in conformance with the requirements and prohibitions of the statute;
- The appeals procedures respecting GHPs and LGHPs that HCFA finds to be nonconforming;
- The referral of nonconforming plans to the Internal Revenue Service; and
- The rules for recovery of conditional or mistaken Medicare payments made by HCFA.

The intent of the MSP provisions is to ensure that Medicare does not pay primary benefits for services for which a GHP or LGHP is the proper primary payer and that beneficiaries covered under these plans are not disadvantaged vis-a-vis other individuals who are covered under the plan but are not entitled to Medicare.

**DATES:** *Effective Dates:* These regulations are effective on October 2, 1995.

*Comment Date:* We will consider comments that we receive no later than 5 p.m. on October 30, 1995.

**ADDRESSES:** Mail an original and 3 copies of written comments to the following address:

Health Care Financing Administration,  
Department of Health and Human  
Services, Attention: BPD–482–FC,  
P.O. Box 26676, Baltimore, MD 21207.

If you prefer, you may deliver original and 3 copies of your written comments to one of the following addresses:

Room 309–G, Hubert H. Humphrey  
Building, 200 Independence Avenue,  
SW., Washington, DC 20201, or

Room C5–09–26, 7500 Security  
Boulevard, Baltimore, MD 21244–  
1850.

Because of staffing and resource limitations, we cannot accept comments by facsimile (FAX) transmission. In commenting, please refer to file code BPD–482–FC. Comments received timely will be available for public inspection as they are received, generally beginning approximately 3 weeks after publication of a document, in Room 309–G of the Department's offices at 200 Independence Avenue, SW., Washington, DC, on Monday through Friday of each week from 8:30 a.m. to 5 p.m. (phone: (202) 690–7890).

For comments that relate to information collection requirements, mail a copy of comments to:

Office of Information and Regulatory  
Affairs, Office of Management and  
Budget, Room 10235, New Executive  
Office Bldg., Washington, D.C. 30503,  
Attention: Allison Herron Eydt, Desk  
Officer for HCFA

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**FOR FURTHER INFORMATION CONTACT:**  
Herbert Pollock, (410) 786–4474.

## SUPPLEMENTARY INFORMATION:

**I. Background**

During the first 15 years of the Medicare program, Medicare was the primary payer for all Medicare-covered services with the sole exception of services covered under workers' compensation as provided in section 1862 of the Act. Beginning in 1980, the Congress passed a series of amendments to section 1862 of the Act to make Medicare the secondary payer for services covered by other types of insurance. In general, Medicare is now secondary to all of the following:

1. All forms of liability insurance.
2. Automobile and non-automobile no-fault insurance.
3. Group health plans (GHPs) that cover end-stage renal disease (ESRD) patients (during the first 18 months of Medicare eligibility or entitlement).
4. GHPs that cover aged individuals who have current employment status with an employer and aged spouses of individuals of any age who have current employment status with an employer.
5. Large group health plans (LGHPs) that cover disabled individuals if the individual or a member of the individual's family has current employment status with an employer. (Current employment status is sometimes referred to as "current employment.")

**II. Statutory Amendments****A. Overview**

1. Section 9319 of the OBRA '86 (Pub. L. 99-509) added a new section 1862(b)(4), which made Medicare secondary to benefits payable by "large group health plans" for services furnished to "active individuals," who are entitled to Medicare based on disability.

2. Section 6202(b) of OBRA '89 (Pub. L. 101-239) reorganized and clarified the Medicare secondary payer (MSP) provisions and transferred the provisions applicable to the disabled to section 1862(b)(1)(B) of the Act.

3. Section 4204(g) of OBRA '90 (Pub. L. 101-508) added a new section 1862(b)(3)(C), which prohibits employers and other entities from offering Medicare beneficiaries incentives not to enroll or to terminate enrollment in a GHP that would otherwise be primary to Medicare. Section 1862(b)(3)(C) of the Act provides for a civil money penalty of up to \$5,000 for each violation.

Section 4203(c)(1) of OBRA '90 redefined the 12-month ESRD MSP coordination period, during which GHPs are required to pay primary to

Medicare, and extended that redefined period from 12 to 18 months. A final rule with comment period addressing the section 4203(c)(1) changes was published in the **Federal Register** on August 12, 1992 (57 FR 36006-36016).

4. Section 13561(e) of OBRA '93 (Pub. L. 103-66), effective August 10, 1993, changed the MSP provisions for the disabled to make Medicare the secondary payer for individuals who have LGHP coverage by virtue of the individual's own or a family member's "current employment status with an employer". An individual has current employment status with an employer if the individual is an employee, is the employer (including a self-employed person), or is associated with the employer in a business relationship. In general, this means that the individual is on the employment rolls of the employer. Before this change in the law, Medicare was also secondary payer for certain nonworking disabled individuals who were considered to have employee status based on their relationship with the employer, even though they may not have been on the employment rolls.

5. Sections 151(c) and 157(b) of the Social Security Act Amendments of 1994 (SSAA '94) (Pub. L. 103-432) made miscellaneous and technical corrections to OBRA '89, OBRA '90, and OBRA '93. Section 151(b)(3) added express authority to assess interest if a conditional Medicare payment is not refunded within 60 days.

**B. OBRA '86 Amendments—Active Individuals Entitled to Medicare on the Basis of Disability**

These amendments—

1. Defined the term "active individual" as "an employee (as may be defined in regulations), the employer, an individual associated with the employer in a business relationship, or a member of the family of any of such persons."

2. Defined "large group health plan" by reference to section 5000(b) of the Internal Revenue Code (IRC) of 1986, which defined the term as "a plan of, or contributed to by, an employer or employee organization (including a self-insured plan), to provide health care (directly or otherwise) to the employees, former employees, the employer, others associated or formerly associated with the employer in a business relationship, or their families, that covers employees of at least one employer that normally employed at least 100 employees on a typical business day during the previous calendar year." (We have interpreted the phrase "normally employed at least 100 employees on a typical business day" to

mean that the employer employed at least 100 full-time or part-time employees during 50 percent or more of the employer's business days during the previous calendar year.)

3. Provided that Medicare may not pay for services furnished to an active individual on or after January 1, 1987, and before January 1, 1992, to the extent that payment has been made or can reasonably be expected to be made by an LGHP. (Section 4203(b) of OBRA '90 changed the sunset provision from January 1, 1992, to October 1, 1995, and section 13561(b) of OBRA '93 changed that date to October 1, 1998.)

4. Expanded HCFA's recovery rights under previous amendments to the Medicare statute by providing that HCFA may bring an action against any entity that fails to pay primary benefits for services furnished to active individuals entitled on the basis of disability, as required under section 1862(b) of the Act, and may collect double damages.

5. Created a private cause of action under which any claimant may seek double damages from any entity responsible for payment that fails to pay primary benefits as required by the statute.

6. Provided that an LGHP "may not take into account that an active individual is eligible for or receives" Medicare benefits on the basis of disability. The effect of this prohibition was to—

- Make Medicare secondary payer for active individuals who were entitled to Medicare on the basis of disability and whose LGHP coverage was linked to their status as active individuals; for example, individuals who had LGHP coverage because they were employees or spouses of employees; and

- Require the LGHP to treat such active individuals the same way it treated similarly situated individuals.

**C. OBRA '89 Amendments**

The OBRA '89 amendments—

1. Revised the definition of "active individual" to include the phrase "self-employed individual (such as the employer)";

2. Extended to individuals with ESRD and to the aged the prohibition against taking into account Medicare entitlement.

3. Required that GHPs—

- Furnish to aged employees and spouses the same benefits, under the same conditions, that they furnish to employees and spouses under 65; and
- Not differentiate in the benefits they provide between individuals with ESRD and other plan enrollees, on the basis of

the existence of ESRD, the need for dialysis, or in any other manner.

4. Extended to the MSP provisions for the aged and for those with ESRD, the Federal Government's right to recover double damages; and

5. Exempted from the MSP provisions services performed for a religious order by members of the order who take a vow of poverty; and

6. Provided a single formula for determining Medicare secondary payment amounts under all MSP provisions.

#### D. OBRA '90 Amendments

These amendments made the following changes:

1. Added a new section 1862(b)(3)(C) to the Act, which prohibited employers or other entities from offering to an individual entitled to Medicare any financial or other incentive not to enroll, or to terminate enrollment, in a GHP that would be primary to Medicare, unless the incentive was also offered to all individuals who are eligible for coverage under the plan. That section also provided for a penalty of up to \$5,000 for each violation, which was to be applied in accordance with provisions of section 1128A of the Act.

2. Redefined and extended the ESRD MSP coordination period. The 12-month ESRD coordination period was redefined to begin with the first month of ESRD-based eligibility or entitlement, and that redefined period was extended to 18 months. (Previously, the ESRD coordination period was a 12-month period that began with the first month of dialysis rather than with the first month of ESRD-based eligibility or entitlement, which generally occurs as of the fourth month of dialysis.) On August 12, 1992, we published a final rule with comment period (57 FR 36006-36016) that incorporated this change. We received one comment on this particular aspect, but made no change in the confirming final rule published on November 2, 1993 (58 FR 58502-58504).

#### E. OBRA '93—Amendments Treatment of Individuals Entitled to Medicare on the Basis of Disability Who Have LGHP Coverage by Virtue of Their Own or a Family Member's Current Employment Status

The OBRA '93 amendments made the following changes, effective August 10, 1993:

1. Eliminated the concept "active individual" and provided instead that the MSP disability provision applies only if the individual, or a family member, is covered under an LGHP "by

virtue of the individual's current employment status with an employer".

2. Provided that an individual has "current employment status" if the individual is an employee, the employer (including a self-employed person), or is associated with the employer in a business relationship.

3. Required use of the IRS aggregation rules for determining employer size under the working aged and disability provisions.

4. Modified the MSP provisions for individuals who are eligible for or entitled to Medicare on the basis of ESRD and also entitled on the basis of age or disability.

5. Clarified that GHPs and LGHPs of governmental entities are subject to the MSP provisions (although governmental entities are exempt from the excise tax applicable to employers that participate in nonconforming plans.)

#### F. The Social Security Act Amendments of 1994 (SSAA '94)

The SSAA '94 made the following miscellaneous and technical corrections:

1. Effective as if included in the enactment of OBRA '93—

A. Clarified that plans must offer the same benefits under the same conditions to the age 65 or older spouse of any employee; that is, without regard to the employee's age. (With regard to spouses, the wording of OBRA '93 could have been misconstrued as applying the working aged provision only to age 65 or older spouses of employees age 65 or older.) (Section 151(c)(1).)

B. Clarified that GHPs and LGHPs of governmental entities have *always* been subject to the MSP provisions. (OBRA '93 could have been misconstrued as providing that plans of governmental entities are subject to the MSP provisions only as of August 10, 1993, the date of enactment of OBRA '93, whereas governmental entities have always been subject to the MSP provisions, with the exception of the excise tax applicable to employers that participate in the nonconforming plans.) (Sections 151(c) (9) and (10).)

2. Effective as if included in the enactment of OBRA '90—

A. Clarified that employers and other entities are prohibited from offering to an individual entitled to Medicare any financial or other incentive not to enroll in, or to terminate enrollment in, a GHP that would be primary to Medicare, irrespective of whether the incentive is also offered to all other individuals who are eligible for coverage under the plan. (Section 157(b)(7). Refer to section VIII-K of this preamble.)

B. Clarified the extent to which section 1128A of the Act applies to the civil money penalty of section 1862(b)(3)(C) of the Act. (Section 157(b)(7). Refer to section VIII-K of this preamble.)

3. Effective as if included in the enactment of OBRA '89—Clarified that under section 1862(b)(1)(C) plans may pay benefits secondary to Medicare after the 18-month period during which the plan is prohibited from taking into account ESRD-based eligibility or entitlement but may not otherwise differentiate in benefits provided vis-a-vis other plan enrollees. The OBRA '89 language could have been misconstrued as permitting plans to discriminate against enrollees who had ESRD after the 18-month coordination period. That is, OBRA '89 broadly stated that plans were not prohibited from "taking into account" ESRD-based eligibility or entitlement after the 18-month coordination period; the SSAA '94 corrected that language to narrowly state that plans are not prohibited from paying benefits secondary to Medicare after the 18-month coordination period. (Section 151(c)(5). Refer to section VIII-D of this preamble.)

The SSAA '94 also added express authority to assess interest if a conditional Medicare primary payment is not refunded within 60 days. As authorized under common law, and in accordance with HHS regulations, consistent with the Federal Claims Collection Act (31 U.S.C. 3711), HCFA may charge interest on amounts that any responsible party does not refund timely. Section 151(b)(3) amended section 1862(b)(2)(B)(i) of the Act to make explicit that the Secretary may charge interest when timely reimbursement is not made. This self-implementing statutory clarification is effective for items and services furnished on or after the date of enactment, October 31, 1994. The rate of interest provided in section 1862(b)(2)(B)(i) of the Act is the same as in sections 1815(d) and 1833(j), which is reflected in regulations at 42 CFR 405.376(d). We will include detailed policies regarding the statutory provision in a future regulation. (Refer to section VIII-L of this preamble.)

#### III. Study by the Comptroller General

OBRA '86 required the Comptroller General to conduct a study to determine the impact of the MSP provisions for the disabled on the access that disabled individuals and members of their families have to employment and health insurance. In the April 10, 1991, report entitled *Medicare: Millions in Disabled Beneficiary Expenditures Shifted to*

*Employers*, the Comptroller General concluded that "The OBRA '86 secondary payer provision has met its objective of shifting considerable Medicare expenditures to LGHPs apparently without significant adverse effect" on the access of disabled beneficiaries and their families to employment and health services. The report further stated: "In addition to suffering little adverse effect from the provision, the disabled are safeguarded by regulations proposed by HCFA. These rules discourage employers from taking many of the actions they were considering that would discriminate against disabled beneficiaries and their families in regard to health insurance." The report also recommended that HCFA change its policy to remove the "indicators" that, prior to the changes made by OBRA '93, were used to determine whether an individual who is not actively working for an employer is considered an employee. That recommendation echoes those made by many of the commenters in their responses to the proposed rules published on March 8, 1990 at 55 FR 8491.

#### IV. Related Statutes

##### A. Internal Revenue Code (IRC)

1. OBRA '86 also amended the IRC to—

- Define "nonconforming group health plan" as a large group health plan that at any time during a calendar year takes into account that an active individual is eligible for or is receiving Medicare benefits based on entitlement to Social Security disability benefits; and

- Impose, on any employer or employee organization (other than a governmental entity) that contributes to a nonconforming LGHP, a tax equal to 25 percent of the expenses the employer or employee organization incurred during the calendar year for each LGHP to which the employer or employee organization contributes.

2. OBRA '89 further amended the IRC to—

- Substitute the following definition of "nonconforming group health plan" to replace the OBRA '86 definition.

"For purposes of this section, the term nonconforming group health plan means a group health plan or large group health plan that at any time during a calendar year does not comply with the requirements of subparagraphs (A) and (C) or subparagraph (B), respectively, of section 1862(b)(1) of the Social Security Act."

- Provide that the tax imposed by OBRA '86 on employers and employee organizations that contribute to or

sponsor LGHPs that do not comply with the MSP provisions for the disabled also applies with respect to such sponsors or contributors that do not comply with the MSP provisions for the working aged or the MSP provisions for ESRD beneficiaries.

- OBRA '93 expanded the definition of "nonconforming group health plan" to include a group health plan or LGHP that fails to refund to HCFA conditional primary Medicare payments.

Under these IRC amendments, HCFA reports to the IRS GHPs and LGHPs that do not comply with any of the following:

- The prohibition against taking into account Medicare entitlement when Medicare is the secondary payer for aged, ESRD, or disabled beneficiaries.

- The requirement that employees and spouses age 65 or older be given equal benefits under the same conditions as those under 65.

- The prohibition against differentiating, in the services covered and payments made, between persons having ESRD and other individuals covered by the plan.

- The requirement that GHPs and LGHPs refund conditional primary Medicare payments.

##### B. Americans With Disabilities Act

The Americans with Disabilities Act of 1990, Pub. L. 101-336 (42 U.S.C. 12101 et seq.) is related to the aims of this rule with respect to the MSP provision for the disabled. Section 102 of that statute prohibits discrimination against the physically or mentally disabled in private places of employment. This Act is administered by the Equal Employment Opportunity Commission.

##### C. COBRA Continuation Coverage Amendments

Title X of the Consolidated Omnibus Budget Reconciliation Act of 1985 (Pub. L. 99-272, commonly referred to as COBRA) amended the following statutes:

- Section 4980B of the IRC (26 U.S.C. 4980B).

- Part 6 of title I, subtitle B of the Employee Retirement Income Security Act (ERISA) (29 U.S.C. 1161-1168).

- Title XXII of the Public Health Service Act (42 U.S.C. 300bb-1 et seq.)

Under the COBRA amendments, certain GHPs must offer employees (and their dependents), who would otherwise lose coverage under the plan as a result of any of five specified "qualifying events", an opportunity to elect continuation of the coverage they had immediately before the qualifying event. "Qualifying events" include termination

of employment (other than for gross misconduct) and reduction in hours of work. Continuation coverage must extend at least from the date of the qualifying event to the earliest of a list of terminating events. Terminating events include entitlement to Medicare and expiration of the maximum period of continued coverage specified for a particular qualifying event. For termination of employment or reduction of hours of work, the maximum coverage period is 18 months. This is extended to 29 months in the case of a qualified beneficiary who is determined to have been disabled at the time of the qualifying event. For other qualifying events the maximum is generally 36 months.

GHP COBRA continuation coverage is generally exempt from the Medicare secondary payer provisions. Part VII-E of this preamble contains a detailed discussion of the MSP provisions vis-a-vis the COBRA provisions.

#### V. Provisions of the Proposed Rule

The March 8, 1990, notice of proposed rulemaking proposed to add a new subpart G to part 411—Exclusions from Medicare and Limitations on Medicare Payment.

At that time, subpart B of part 411 set forth general rules and definitions applicable to all of the Medicare secondary payer provisions. Included were rules on recovery and waiver of recovery, Medicare secondary payments, and the effect of third-party payments on benefit utilization and deductibles. Accordingly, proposed subpart G included only those rules that apply exclusively to LGHPs or that differed to some extent from similar rules applicable to other third party payers.

A. In Section 411.82, Definitions, we proposed to—

1. Interpret "typical business day" as 50 percent or more of the employer's regular business days during the previous calendar year; and

2. Define "employee" as an individual who is actively working or whose relationship to an employer shows that he or she has employee status within the ordinary understanding of the term "employee." In § 411.83, Determination of Employee Status, we proposed that employee status be established if the individual met any of the following conditions:

- Received from an employer payments that are subject to taxes under the Federal Insurance Contributions Act (FICA) or would be subject to such taxes except for the fact that the payment is exempt from those taxes under the IRC.

- Was termed an employee under a Federal or State law or in accordance with a court decision.

- Was designated as an employee in the employer's records; that is, had not had his or her employee status terminated. We proposed that termination from payroll, in and of itself, not be considered termination from employee status.

We also gave examples of other commonly accepted indicators of employment status, examples that we developed in consultation with other government agencies, including the Department of Labor and the IRS.

We considered adding the following indicators to the list that appeared in proposed § 411.83(b):

- Accrues years of service credits for pension purposes (that is, the individual's age-based pension rights continue to increase); and
- May become vested under the employer's retirement plan, even though he or she was not vested at the time the disability was established.

We specifically requested comments on whether to include these two indicators in the final rule.

B. In Section 411.88, Basis for Medicare primary payments, we proposed that failure to furnish information necessary for HCFA to determine whether an LGHP was primary to Medicare could lead to denial of payment of Medicare primary benefits.

The proposed rule also—

1. Defined three key terms as follows:

- “Disabled active individual”, as an active individual who has been determined to be “under a disability” under section 223 of the Act, as evidenced by issuance of an SSA notification to that effect, and who is not, and could not upon filing an application become, entitled to Medicare on the basis of ESRD.

- “Nonconforming LGHP”, as an LGHP that, at any time during a calendar year, discriminates against a disabled active individual who is eligible for, or receives, Medicare benefits on the basis of disability.

- “Family member”, as any person whose relationship to the active individual is the basis for coverage under an LGHP; for example, the relationship of a divorced or common law spouse or that of an adopted, foster, natural or step-child, parent, or sibling.

2. Specified that a disabled active individual could accept or reject the LGHP coverage offered by the employer, and that, if the individual refuses the LGHP, the employer may not offer a plan that pays benefits secondary to Medicare.

3. Provided examples of LGHP actions that would be considered discriminatory.

4. Indicated the kinds of information that HCFA might require to document an LGHP's compliance with the nondiscrimination rule.

5. Specified that HCFA would refer to the IRS any LGHP that it finds to be a nonconforming LGHP.

6. Specified that the IRS imposes, on employers or employee organizations that contribute to a nonconforming LGHP, the tax provided for under section 5000 of the IRC of 1986.

## **VI. Reorganization of the Rules and Conforming Changes**

Because of the statutory changes discussed above, we needed a new subpart for the provisions that now apply generally to all GHP MSP situations. We also needed to make room for incorporating in logical order any additional regulations that may be required by future amendments to the Act. Accordingly, this final rule—

- Redesignates subparts E and F as F and G, respectively;

- Establishes a new subpart E for the general provisions, including appeals provisions that were not in the NPRM; and

- Designates the special provisions for the disabled under a new subpart H. New subpart E includes—

- Most of the definitions that were previously scattered among several subparts (§ 411.101).

- A statement of the basic prohibitions under the ESRD, working aged, and disability MSP provisions (§ 411.102).

- A statement of the prohibition against employers offering incentives to encourage Medicare beneficiaries not to enroll in or to terminate enrollment in a GHP that would be primary to Medicare (§ 411.103).

- An explanation of the terms “current employment status” and “coverage by virtue of current employment status” (§ 411.104).

- The method for determining employer size (§ 411.106).

- Examples of actions that constitute “taking into account” Medicare entitlement and of permissible actions (§ 411.108).

- Basis for determination of nonconformance (§ 411.110).

- Documentation of conformance (§ 411.112).

- Determination of nonconformance and notice of that determination (§§ 411.114 and 411.115).

- Appeals procedures (§§ 411.120 through 411.126).

- Referral to IRS (§ 411.130).

The following table shows how the section numbers in the final rule differ from the numbers in the NPRM. The revised designations reflect the reorganization of the text required by the addition of rules that now apply to all three groups of beneficiaries (aged, disabled, and ESRD) and the new rules on appeals procedures.

Heading as shown in final rule	Proposed rule designation section	Final rule designation section
Basis and scope .....	411.80 .....	411.100
Definitions .....	411.82 .....	411.101; 411.201
Current employment status .....	411.83 .....	411.104
Medicare benefits secondary to LGHP benefits .....	411.85 .....	411.204
Basis for Medicare primary payments and limits on secondary payments .....	411.88 .....	411.206
Recovery of conditional Medicare payments .....	411.92 .....	411.24
Basic prohibitions and requirements .....	411.94(b) .....	411.102
Taking into account entitlement to Medicare .....	411.94(d) .....	411.108
Basis for determination of nonconformance .....	411.94(c) .....	411.110
Documentation of conformance .....	411.94(e)&(f) .....	411.112
Determination of nonconformance .....	411.94(d) .....	411.114
Referral to the Internal Revenue Service (IRS) .....	411.94(g) .....	411.130

**Note:** The headings are those used in the final rule. In referring to the proposed rule

in the preamble discussion, we use the

column 1 designations. In referring to the final rule, we use the column 2 designations.

The statutory changes, the reorganization of the regulations text, and other changes that have occurred since these rules were published required the following conforming changes in subpart B:

1. Revise § 411.20 (Basis and scope) to—

- Transfer to the new subpart E the statutory basis for the rules that apply to GHP coverage.
- Reflect this change in the “Scope” paragraph of the section.
- Expand references (in this section and in § 411.21) to include the new subpart H.

2. Revise § 411.24 (Amount of recovery) as follows:

- a. In paragraph (c), to—
  - Reflect the fact that OBRA '89 extended to all MSP situations the right (previously limited to MSP for the disabled) to recover double the amount of damages if it is necessary for HCFA to take legal action in order to recover;
  - Remove the parenthetical reference to the double damages provision and expressly state the circumstances under which HCFA can recover double damages; and
  - Specify that responsible parties include both third party payers and individuals or entities that have received third party payments that must be refunded.
- b. In paragraph (e), to make clear that third parties against which HCFA may take action are those that are “required to make”, as well as those who are “responsible for making”, primary payments. This change is necessary to conform to a language change made by OBRA '89.

c. To add a new paragraph (m) (Interest charges) to specify the explicit authority provided by the Social Security Act Amendments of 1994, which is in addition to the long-standing authority provided by common law and by HHS regulations (45 CFR 30.13) that are consistent with the Federal Claims Collection Act (31 U.S.C. 3711), for HCFA to charge interest on amounts that any responsible party does not refund timely.

3. Amend § 411.33 (Amount of Medicare secondary payment) to make clear that Medicare payment may now be based on fee schedules (as well as reasonable charge) and to remove paragraphs (c) and (d), which set forth a special formula for computing Medicare secondary payments under the MSP provisions for ESRD. (OBRA '89 provided a single formula for all MSP situations.)

## VII. Comments on the NPRM of March 8, 1990 and Responses to Those Comments

We received 36 timely letters of comment from employers, insurance companies, law firms, actuarial firms, individuals, associations (two business and one medical), and beneficiary rights organizations. Following is a discussion of those comments and our responses to them.

Thirty-three of the comments dealt with the term “active individual,” including the statutory definition of that term. Since the term “active individual” was deleted from the law by OBRA '93, effective August 10, 1993, we are not responding to those comments, except for the comment in A. below.

### A. Definitions—(Section 411.82)

The law prior to OBRA '93 defined the term “active individual” as “an employee (as may be defined in regulations), the employer, self-employed individual (such as the employer), an individual associated with the employer in a business relationship, or a member of the family of any of such persons.” We received a comment about one of the categories under this definition; that is, “individual associated with the employer in a business relationship.”

*Comment:* The commenter suggested that the rules define the term “individual associated with the employer in a business relationship.” The commenter went on to propose that individuals who are receiving health care coverage through an employer are associated with the employer in a business relationship regardless of whether they are employees. The commenter suggested that such a definition would be appropriate because employers provide such benefits as part of a *quid pro quo* for services.

*Response:* We do not agree that a definition of the term “individual associated with the employer in a business relationship” is necessary in the regulations. Any individual who qualifies for LGHP coverage because of a business relationship with the employer (for example, suppliers and contractors who do business with the employer) is included within the term. We also do not agree with the commenter's proposed definition of the term. Defining the term in the manner proposed would bring many former employees, including retirees, who receive benefits from an employer within the scope of the MSP provision for the disabled. The Congress clearly did not intend the MSP provision for the disabled to extend to retirees and

other former employees, since the term “former employee under age 65” was specifically deleted from an early draft of legislation on MSP for the disabled legislation (Senate Report 99-348 July 31, 1986).

*Comment:* One commenter objected to the inclusion of “divorced spouse” in the definition of “family member”. The commenter contended that the inclusion of that term exceeded HCFA's authority, since a “former family member” is not a “family member”.

*Response:* We disagree. As used in new subpart H, “family member” means anyone who has LGHP coverage on the basis of another person's enrollment. Spouses, children, parents, and siblings are merely examples. Any individual to whom a LGHP grants coverage because of such an enrollment is a family member for purposes of subpart H.

*Comment:* One commenter asked why the term “spouse who was married to an active individual” was not included in the definition of “family member.” The commenter also requested clarification of the status of an ex-spouse who is eligible to receive or is receiving health care benefits under the continuation of coverage provisions of COBRA and what is the LGHP's obligation to such an individual.

*Response:* We have revised the definition of “family member” to include the term “spouse”. The matter of an ex-spouse is discussed in response to the previous comment. The rules that apply to disabled individuals who have LGHP benefits as a result of the COBRA continuation provisions are discussed under Part VII-E of this preamble.

*Comment:* One commenter objected to inclusion of an “employee-pay-all” plan in the definition of LGHP in the proposed rule (§ 411.82(4)(ii)) on the basis that these plans are generally “franchise arrangements” in which the contracts are individually underwritten and the employer merely performs the ministerial role of collecting the premiums but not enrolling the participants.

*Response:* We have considered the status of “employee-pay-all plans” in the past and addressed the issue in the preamble to the Medicare regulations published on October 11, 1985 (50 FR 41503), and in § 411.70(d) of the Medicare regulations published on October 11, 1989 (54 FR 41745). Those regulations apply to the working aged and make clear that “employee-pay-all” plans may satisfy the statutory definition of GHP. We apply the same principles in the MSP rules for the disabled. (See 52 FR 35966, September 24, 1987.)

Medicare is secondary to "employee-pay-all" plans if they meet the statutory definition of LGHP; that is, plans that are under the auspices of, or contributed to, by an employer or employee organization and that cover at least one employer of 100 or more employees.

*Comment:* One commenter requested that the term "Medicare payment" in § 411.92, Recovery, should be defined to eliminate confusion with another term, "gross amount payable", used in Medicare contractor manuals.

*Response:* The term, "gross amount payable", is defined at 42 CFR 411.33(e)(1) as "the amount payable without considering the effect of the Medicare deductible and coinsurance or the payment by the third party payer \* \* \*."

We have revised proposed § 411.92 (now § 411.24) to specify that HCFA recovers the Medicare primary payment amount.

*Comment:* A commenter objected to the definition of LGHP, because it casts too broad a net and captures many employers who have fewer than 100 employees, but who are required to provide primary coverage to disabled active individuals because these "small employers" participate in a plan that has at least one employer of 100 or more employees.

*Response:* The term "large group health plan" is defined in the IRC of 1986 as "a plan of, or contributed to by, an employer or employee organization (including a self-insured plan) to provide health care (directly or otherwise) to the employees, former employees, the employer, others associated or formerly associated with the employer in a business relationship, or their families, that covers employees of at least one employer that normally employed at least 100 employees on a typical business day during the previous calendar year." HCFA has no discretion to exempt from the Medicare secondary payer provision for the disabled employees of employers of fewer than 100 employees if they belong to a multi-employer plan that meets the above definition. In the MSP statute, as revised by OBRA '89, the Congress could have provided an exception for small employers that participate in multi-employer or multiple employer plans, similar to the exception that is specifically provided in the statute with respect to the working aged. Since the Congress chose to provide the exception only under the working aged provision, we conclude that it was not the Congress' intent to allow a similar exception under the MSP provision for the disabled.

## B. Indicators of Employee Status

We received 30 comments on § 411.83, which proposed to incorporate into the regulations the policy that some disabled individuals who are not working are considered to be employees for MSP purposes if certain indicators of "employee status" are present. Only one commenter supported the policy without reservation. The other commenters expressed either opposition to the policy as a whole or to one or more of the indicators used to establish whether a non-working disabled person has employee status. We are not addressing these comments because we have deleted the policy on indicators of employee status, to reflect changes made by OBRA '93, effective August 10, 1993. In the legislative history that preceded enactment of OBRA '93 (Conference Report of the House Committee on the Budget to accompany H.R. 2264, H.R. Rep. No. 213, 103rd Cong. 1st Sess. (1993)), the Congress provided explicit direction on how it expected us to construe the new law. It made clear on page 805 that the term "current employment status with an employer" should be implemented "consistent with the provision that applies to aged beneficiaries (working aged)" and, on page 806, that "the definition of active employee for disabled beneficiaries (should) conform with the definition for working aged beneficiaries."

## C. Prohibition of Discrimination

Several commenters addressed the provisions of proposed § 411.94, which dealt with the prohibition of discrimination by LGHPs against disabled active individuals on the basis of Medicare entitlement.

*Comment:* One commenter requested that HCFA discard all of the rules on nondiscrimination on the grounds that "they represent an unjustified and unsupported foray into the role of the Congress." In the event that HCFA decides to promulgate the proposed nondiscrimination rules, the commenter requested that HCFA conduct public hearings to gauge the effect of the rules.

*Response:* Under the law in effect before August 10, 1993, section 1862(b)(1)(B)(i) of the Act prohibited LGHPs from "taking into account" that an active individual is entitled to Medicare on the basis of disability. As amended by OBRA '93, the law prohibits LGHPs from taking into account the entitlement to Medicare on the basis of disability of an individual who has LGHP coverage by virtue of the individual's own or a family member's current employment status. This

provision simultaneously makes Medicare benefits secondary to LGHP coverage for these individuals and prohibits LGHPs from taking into account that these individuals are entitled to Medicare on the basis of disability. For example, without this prohibition LGHPs could deny, reduce, or restrict coverage or access to coverage for these individuals and thereby shift to the Medicare program the primary responsibility for payment of their medical expenses. This would defeat the purpose of the MSP provision for the disabled.

The public has had ample opportunity to comment on the proposed nondiscrimination rules during the public comment period that followed the publication of the notice of proposed rulemaking. We received a number of substantive comments regarding the proposed nondiscrimination rules, and we discuss these comments below. We therefore do not believe that there is need for public hearings on the final rules.

*Comment:* Several commenters objected that the criteria for prohibited discrimination in proposed § 411.94(d) exceed the statutory requirement. These commenters contended that while the statute prohibits LGHPs only from denying coverage to disabled active individuals on account of their Medicare entitlement, the criteria in proposed § 411.94(d) appear to prohibit LGHPs from terminating disabled individuals on grounds other than Medicare entitlement. One commenter expressed concern that an employer would be unable to terminate a disabled active individual's coverage for any reason after the individual becomes entitled to Medicare. Another commenter recommended that the final rule specify that prohibited discrimination occurs only when a plan treats disabled active individuals differently from "similarly situated" individuals not entitled to Medicare.

*Response:* The statute, as amended by OBRA '86, prohibited an LGHP from taking into account that an active individual is entitled to Medicare on the basis of disability. As amended by OBRA '93, the statute prohibits LGHPs from taking into account entitlement to Medicare on the basis of disability of an individual who has LGHP coverage by virtue of the individual's own or a family member's current employment status. The basic rule is that, with regard to individuals entitled to Medicare on the basis of disability who (1) have current employment status or (2) are family members of individuals with current employment status, LGHPs must offer the same enrollment opportunities



and the same coverage under the same conditions as they offer to similarly situated individuals. In the case of employees, all other employees enrolled or seeking to enroll in the plan are considered to be similarly situated. In the case of each of the other categories of individuals who have current employment status (such as business associates or family members), all other persons in those categories are considered to be similarly situated.

An LGHP may refuse to provide coverage, terminate enrollment, or limit coverage (for individuals who are entitled to Medicare on the basis of disability) only on grounds that apply to all similarly situated individuals enrolled, or seeking to enroll, in the plan, including individuals not entitled to Medicare. Plan provisions that have the effect of denying, restricting, or terminating benefits for disabled beneficiaries who have LGHP coverage by virtue of current employment status, but not for similarly situated individuals, are prohibited. An LGHP may make benefit distinctions among various categories of similarly situated individuals, distinctions based, for example, on length of time employed, employment status, or marital status but not on disability. If the LGHP makes such distinctions, it may also make them among disabled beneficiaries who have LGHP coverage by virtue of current employment status.

*Comment:* Several commenters objected that proposed § 411.94(d) appeared to force employers to decide, before an employee who has become disabled is determined to be "under a disability" within the meaning of section 223 of the Social Security Act, whether to cease covering the individual under the LGHP or to continue providing benefits for as long as benefits are provided to active employees. One commenter contended that the Congress clearly did not intend to impose such a choice upon employers. Another commenter noted that the proposed policy would only encourage employers to cut off health benefits to injured workers before the individual receives a determination of disability from the Social Security Administration.

*Response:* In the NPRM, we proposed to compare what an LGHP offers or provides at or after the point of disability determination with what it offered or provided at or after the point of Medicare entitlement. The idea was to prevent employers from avoiding the obligation of providing primary benefits by terminating coverage during the 29 month waiting period between the onset of disability and Medicare entitlement.

We agree that the proposed policy could be interpreted as encouraging employers to terminate coverage of injured or sick workers prior to the determination of disability. In addition, the proposed policy could lead to an anomalous situation in which an LGHP's changing or termination of a disabled individual's coverage would be permissible or impermissible, depending on the variable timing of disability determinations.

We are, therefore, not including the proposed policy in the final regulation. The prohibition against taking Medicare entitlement into account does not compel LGHPs to make an irrevocable choice, before the determination of disability, between discontinuing coverage of disabled individuals and providing coverage indefinitely. Rather, as discussed earlier in this preamble, LGHPs are prohibited from treating individuals entitled to Medicare on the basis of disability and covered by virtue of their own or a family member's current employment status differently from similarly situated individuals (that is, individuals of the same category such as spouse, child, or employee) who are enrolled or seeking to enroll in the plan. No change, restriction, or termination of coverage may be imposed because individuals are entitled to Medicare on the basis of disability. Also prohibited are changes, restrictions, or terminations of coverage that have the effect of treating those individuals differently from similarly situated individuals.

*Comment:* Several commenters raised questions about the application of the nondiscrimination rules to various employer health plan provisions.

- Proposed § 411.94(d) appears to prohibit employers from terminating or amending their health benefits plans, if doing so would have the effect of reducing or terminating benefits provided under an LGHP to a disabled active individual.

- Proposed § 411.94(d)(6) (denial or termination of coverage of a disabled active individual on the basis of disability) would prevent employers from offering employees who become disabled, coverage under an LGHP for a limited period of time and then terminating the coverage once the designated period has expired. This could be interpreted to prohibit employers who voluntarily provide extended coverage to disabled individuals from terminating the extended coverage once the individual becomes entitled to Medicare benefits.

- The rules prohibiting discrimination should not prevent an employer from changing the status of a disabled individual in a way that

disqualifies the individual for coverage under the employer's LGHP. For example, an employer should not be considered to be discriminating if he removes a disabled individual from the roster of employees, thus disqualifying the individual from coverage under the employer's plan.

- Proposed § 411.94(d)(3) appears to provide that an LGHP is discriminatory if it has a policy of offering "disabling condition-only" coverage to employees who become disabled, since such coverage is less comprehensive than coverage provided to other individuals under the plan.

*Response:* An employer is not prohibited from adopting any of the provisions described above, provided that those provisions (1) apply to all enrollees and potential enrollees, without regard to whether they are entitled to Medicare on the basis of disability; and (2) do not have the effect of treating disabled Medicare beneficiaries who have LGHP coverage by virtue of current employment status differently from similarly situated individuals.

Thus, a "disabling condition-only" provision is prohibited if it has the effect of restricting coverage for individuals entitled to Medicare on the basis of disability but not for similarly situated individuals who are not so entitled. The regulation does not allow an employer to terminate the LGHP coverage of those disabled individuals unless the employer also terminates coverage for similarly situated individuals not entitled to Medicare on the basis of disability.

If an employer voluntarily provides LGHP coverage to an individual who is entitled to Medicare on the basis of disability and who has LGHP coverage by virtue of current employment status, that coverage is primary to Medicare.

We do not believe that the statute prohibits employers from terminating a benefit that they voluntarily provide to those disabled individuals above the coverage given to similarly situated individuals who are not entitled to Medicare on the basis of disability (see item b. of comment).

Section 411.108 of this final rule makes clear that an LGHP may not, for example, deny or terminate coverage, offer less comprehensive coverage, or charge increased premiums for individuals entitled to Medicare on the basis of disability and covered by virtue of current employment status unless it takes the same actions for similarly situated individuals who are not so entitled. However, as stated above, employers are not required to continue indefinitely LGHP coverage that they



have voluntarily provided to those disabled individuals.

*Comment:* One commenter objected that the nondiscrimination criteria of proposed § 411.94(d) failed to prohibit cost avoidance techniques used by LGHPs and employers to reduce their exposure. One such tactic is to "churn" insurance contracts in order to reimpose waiting periods and pre-existing condition exclusions on "high-exposure" employees and their dependents. Another tactic is to pay "high exposure" individuals an amount equivalent to the per capita premium of the plan so that they can purchase health insurance on an individual basis. The commenter recommended that the criteria in proposed § 411.94(d) specifically prohibit "the payment of wages which are to be dedicated toward the purchase of an individual contract for the disabled active individual."

*Response:* The Medicare law does not prohibit LGHPs from engaging in cost-avoidance practices and from imposing cost-avoidance provisions such as waiting periods and pre-existing condition exclusions, provided that such practices and provisions apply equally to all enrollees and potential enrollees and do not have the effect of treating individuals entitled to Medicare on the basis of disability who have LGHP coverage by virtue of current employment status differently from similarly situated individuals. (However, other State or Federal laws should be consulted for any effect they may have on this situation.)

*Comment:* One commenter asked for guidance about what constitutes adequate notification to active individuals of the consequences of rejecting LGHP coverage, as required under proposed § 411.94(d)(8). The commenter specifically suggested that the rules include a provision that a statement in a Summary Plan Description satisfies this requirement.

*Response:* Beneficiaries need to understand the consequences of rejecting LGHP coverage; that is, that Medicare will be the primary payer and the employer will not be permitted to pay secondary benefits for Medicare-covered services. In recognition of this, we have provided, in § 411.108, that a plan would be taking into account Medicare entitlement if it gave individuals information on their right to accept or reject the employer plan but failed to inform them of the consequences of rejection.

*Comment:* One commenter recommended that proposed § 411.94 provide examples of "taking into account." The commenter offered several examples of "taking into

account" for inclusion in the final regulation.

*Response:* The criteria of proposed § 411.94(d), clarified and expanded on the basis of the commenter's suggestions, appear in the final rule as examples of "taking into account" (§ 411.108).

*Comment:* One commenter recommended that the § 411.94 criteria for determining that an LGHP is discriminating explicitly apply to employees' spouses and dependents, if the LGHP covers them. The commenter also recommended that an LGHP be considered nonconforming if it requires that an active individual receive health care benefits from a prescribed provider, while other covered individuals are not mandated to receive services from that provider.

*Response:* The criteria in proposed § 411.94 and the final rules' examples of "taking into account" clearly apply to employees' spouses and dependents covered by an LGHP, since those persons are included within the meaning of the term "family member." Therefore, it is not necessary to state explicitly in § 411.110 that the criteria that define a nonconforming GHP apply to LGHP coverage of employees' spouses and dependents. An LGHP that required disabled beneficiaries covered by virtue of current employment status, but not similarly situated individuals, to receive services from a preferred provider would clearly be considered nonconforming under the criteria in § 411.110 of the final rule.

#### *D. Referral to the Internal Revenue Service (Section 411.94(g))*

*Comment:* One commenter expressed concern that proposed § 411.94(g), dealing with the reporting of nonconforming LGHPs to the IRS, would not achieve the goal of ensuring nondiscriminatory treatment of active individuals by LGHPs. The commenter recommended that sanctions be incorporated into the rules to provide incentives for LGHPs to meet the nondiscrimination requirements.

*Response:* HCFA reports nonconforming GHPs and LGHPs to the IRS because the IRS administers section 5000 of the IRC, which imposes a tax on employers and employee organizations that contribute to a nonconforming GHP. This provision indicates the Congress' intent that employers and employee organizations be ultimately held responsible for the actions of their health plans. We believe that this tax provides an incentive for employers and employee organizations to ensure that the plans they create, participate in, or contribute to, comply with the

prohibition against taking into account Medicare entitlement. We expect that employers and employee organizations will pursue available remedies under contract or insurance law, if necessary, to assure that their plans comply with the requirements of the statute and thus avoid imposition of the tax. The tax and the requirement to report nonconforming LGHPs were imposed for the disabled by OBRA '86 and extended to all GHP situations by OBRA '89.

*Comment:* One commenter recommended that insurers of LGHPs be reported to the IRS to provide an incentive for them to conform to the requirements of a nondiscriminatory LGHP.

*Response:* See our response to the previous comment. Under section 5000 of the IRC, the tax is imposed only on employers and employee organizations that contribute to nonconforming GHPs. This should discourage employers and employee organizations from doing business with an underwriting insurer that does not conform to the prohibition against taking into account the Medicare entitlement of individuals who are entitled on the basis of age, ESRD, or disability. It should encourage employers and employee organizations to enforce their insurance contracts to ensure that both the promise and the performance under the contract conform to the MSP requirements. Insurers thus should have an incentive to conform with MSP requirements.

Additional incentives for compliance are provided by the following statutory provisions:

- The law provides for a private right of legal action to collect double damages from any entity (including insurers, and employers) that fails to provide primary coverage when required by law.
- The Federal Government has the right to take legal action to collect double damages from those entities if they fail to provide primary benefits.

#### *E. Relation to COBRA Continuation Coverage Provisions*

Under the COBRA continuation coverage provisions, an individual (or the individual's dependents) who would otherwise lose coverage under an employer's GHP because of specified circumstances that include termination and reduction in hours of employment must be offered continued coverage at his or her own expense for a designated period of time. Under a 1989 amendment to the COBRA continuation of coverage provisions, the period of continued coverage is up to 29 months for individuals who were disabled (as determined under the Social Security

Act) at the time of their termination of employment or reduction of hours of work. The COBRA provisions permit termination of continuation coverage at the point of Medicare entitlement, which, for a disabled person, begins 29 months after the onset of disability if the individual has been entitled to monthly social security disability benefits for 24 months. Several commenters raised the following issues:

- The effect of the proposed regulations on coverage provided to active individuals under the COBRA continuation coverage provisions was not clear.

- Section 411.94(d)(6) of the proposed regulations—

- + Appears to have the effect of extending COBRA's limited period of continuation coverage to an unlimited period while an active individual receives Social Security benefits. (That result would be directly contrary to the intent of the Congress).

- + Appears to prohibit LGHPs from terminating continuation coverage of active individuals who become entitled to Medicare benefits, even though COBRA specifically permits this.

- + Could be interpreted to forbid employers who *voluntarily* provide extended coverage beyond the maximum period mandated by COBRA from terminating that coverage once the individual becomes entitled to Medicare.

- HCFA should include in the final regulation a specific rule to the effect that the operation of an LGHP in any manner permitted under the COBRA continuation coverage provision will not be considered discriminatory.

- The proposed regulations create a "very basic conflict" with COBRA. COBRA mandates coverage for individuals who were disabled at the time of a COBRA "qualifying event" for 29 months (which is generally the length of the waiting period for Medicare entitlement based on receipt of Social Security disability benefits) but permits a plan to terminate coverage at the end of the 29 months, or at the point of Medicare entitlement. The proposed regulations, however, do not require coverage during the Medicare waiting period but appear to mandate coverage thereafter.

- Proposed § 411.94(d)(7) appears to prohibit charging active individuals who are also COBRA beneficiaries the higher premiums (up to 150 percent of the applicable premium) permitted under COBRA.

*Response:* When the proposed regulation was published, it was HCFA's position that there was no real conflict between the MSP for the

disabled provision and the COBRA continuation of coverage provision, since COBRA permits but does not mandate termination of coverage at the time of Medicare entitlement. The statutes amended by COBRA state that continuation coverage may be terminated upon entitlement to Medicare. The Medicare statute stated that the LGHP may not take into account entitlement to Medicare based on disability. It was HCFA's policy that the MSP for the disabled provision prohibited termination of COBRA continuation coverage of an active individual entitled to Medicare on the basis of disability if the termination was based on that entitlement. Since some people who have COBRA continuation coverage because they have stopped working would be considered to be employees under the indicators of employee status, the result would be that the proposed regulation would have prohibited what the COBRA law permitted.

Blue Cross and Blue Shield of Texas filed a lawsuit challenging HCFA's same policy with respect to COBRA continuation coverage in ESRD MSP cases (*Blue Cross and Blue Shield of Texas v. Sullivan*, case No. 3-91 2760-H (N.D. Tex.)). On April 7, 1992, the District Court for the Northern District of Texas ruled against the government. The government appealed that ruling to the Fifth Circuit Court of Appeals. On July 13, 1993, the appeals court held that the MSP statute "does not require health plans to provide continuation coverage to individuals who become entitled to Medicare benefits because they have ESRD." *Blue Cross and Blue Shield of Texas v. Shalala*, 995 F.2d 70, 74 (5th Cir. 1993). The court held that the ESRD MSP provision did not modify, nor did it preclude, acts specifically authorized under COBRA.

The issue raised in the Texas case with respect to ESRD was never raised with respect to the MSP provisions for the aged and the disabled. Under previous law the issue might have been raised with respect to the disabled because the MSP provision for them did not require (as it did for the aged) that GHP coverage be based on "current employment".

Under the OBRA '93 amendments, which were effective one month after the appeals court decision, there is no issue for either group because—

- The MSP provisions for both the aged and the disabled apply only when GHP coverage is "by virtue of current employment status"; and

- COBRA continuation coverage is based on termination of employment or on reduction of work hours to the point

where the individual no longer qualifies for coverage based on employment.

This final rule provides (in § 411.161(a)(3)) that a GHP may terminate COBRA continuation coverage if the individual becomes entitled to Medicare on the basis of ESRD, notwithstanding the general prohibition against taking into account eligibility for, or entitlement to, Medicare benefits. Section 411.162(a)(3) makes clear that Medicare is secondary when the plan is required by COBRA to keep the continuation coverage in effect after Medicare entitlement or does so voluntarily. (Changes to the regulation are discussed under part VIII-I of this preamble.)

#### F. Miscellaneous Comments

*Comment:* One commenter asked that the final rules address the situation in which the LGHP paid primary benefits for services provided to an active individual and later learned that the LGHP was not primary payer for the individual because, for example, the individual entitled to Medicare on the basis of disability also has end-stage-renal disease. In that case, the law provides that Medicare is primary payer. The commenter believed that the final rule should provide for HCFA to reimburse the LGHP directly in the same manner that an LGHP must pay HCFA when it failed to make correct primary payments.

*Response:* Under current law, HCFA has an explicit right to recover conditional primary payments from an LGHP. There is no equivalent statutory provision for an LGHP seeking to recover its mistaken payments. HCFA and its intermediaries and carriers do not have authority to pay insurers and other third party payers. Sections 1815(c) and 1842(b)(6) of the Act, respectively, generally preclude payment for provider services to anyone but the provider and preclude payment for services of physicians and other suppliers to anyone other than the supplier or the beneficiary. The limited exceptions allowed do not include payment to LGHPs. Section 3491.15 of the Medicare Intermediary Manual and section 3336.16 of the Medicare Carrier Manual contain instructions for dealing with situations in which third party payers have made mistaken primary payments. The person or entity that receives HCFA's primary Medicare payment would make the refund to the LGHP. If no Medicare claim was originally filed, the provider, supplier or beneficiary may file one, within the time limits specified in §§ 424.44 and 424.45 of the regulations. We note that the situation cited by the commenter

(Medicare is primary payer because the individual is entitled on the basis of disability and also has ESRD) has a different outcome under OBRA '93. For such a dually entitled beneficiary, Medicare is now ordinarily secondary for the first 18 months of ESRD-based eligibility or entitlement.

*Comment:* Two commenters expressed concern that the proposed rules give HCFA the right to recover twice the amount payable by the LGHP as primary payer if HCFA has made conditional primary payments and the LGHP is later determined to have been the primary payer. One of the commenters stated that the proposed rule did not take into account the possibility that the disabled employee may have never filed a claim with the LGHP and only with Medicare. The commenter suggested that LGHP's be exempt from the double damages provision, since the LGHP would be unaware of the existence of a claim for primary benefits. Medicare should instruct beneficiaries to file claims first with the LGHP.

*Response:* The MSP statute provides no authority for us to exempt LGHPs from the double damages provision. However, we have the right to recover double damages only if the LGHP refuses to make appropriate reimbursement. Before instituting legal action to recover our conditional payments, we make every attempt to inform the LGHP of its obligations under the law and of the consequences of failure to comply. We also provide ample time for the LGHP to reimburse the Medicare payments.

We routinely remind beneficiaries and providers and suppliers to file claims first with other insurance and then with Medicare. Medicare intermediaries and carriers deny payment on claims when they have reason to believe that there is another payer responsible for primary payment and instruct the claimant to seek payment from that other source before filing claims under Medicare. Since claims are often filed by the provider or physician or other supplier, we also remind them of their responsibility to determine whether their claims should be filed with entities other than HCFA. In addition, we encourage GHPs and other insurers who are obligated to pay primary to Medicare to inform their Medicare-eligible participants that claims should first be submitted to the responsible primary plan.

*Comment:* One commenter suggested that the employer or other entity not be subject to double damages or to referral to the IRS as a nonconforming GHP if—

- The facts and circumstances show that any noncompliance with the law or regulations was unintentional; or

- The employer relied in good faith on third party administrators, insurers, or other entities to administer or provide health benefits.

Another commenter recommended that, until the final regulations become effective, an employer or plan administrator be protected if he or she acted on the basis of a reasonable good faith interpretation of the statute.

*Response:* There is no provision in the law to extend protection to employers or plan administrators, who act on the basis of a reasonable good faith (albeit erroneous) interpretation of the law, if the GHP or LGHP is found to be a nonconforming GHP. The individuals involved could have sought advice directly from the Medicare contractors or from HCFA. We have in place a comprehensive program to inform the public of its obligations under the MSP provisions. Since the passage of the MSP statute, we have made available to interested parties a variety of informational materials to assist them in complying with this provision. The Medicare intermediaries and carriers and the HCFA regional offices are available to answer questions about the responsibility of employers, insurers, and other entities subject to the MSP provisions.

*Comment:* One commenter noted that Medicare currently makes conditional payments when parties fail to respond to information requests on disabled beneficiaries. The commenter supports continuation of this policy.

*Response:* The basic rule, as set forth in §§ 411.165, 411.175, and 411.206, is that if a provider, supplier, beneficiary, or other party fails to provide information necessary to process a claim, HCFA may deny the claim. However, in order not to disadvantage a beneficiary who may not be responsible for providing the needed information, HCFA considers the specific circumstances of each failure to provide information. Depending on those circumstances, HCFA has in the past made, and may continue to make, conditional payments in some cases for which information is not submitted in response to HCFA's request.

*Comment:* One commenter recommended that provision for an expedited compliance procedure be added to proposed §§ 411.92(a) and 411.94(g) in order to reduce the administrative burden and expense of enforcement. The commenter specifically mentioned the expedited compliance procedure established in HCFA Program Memorandum AB-88-9

(August 1988). That procedure was designed for LGHPs that wish to expedite payments to reimburse HCFA for Medicare conditional primary payments.

*Response:* The expedited compliance procedure established by Program Memorandum AB-88-9 was based specifically on the concept of "active individual". Since OBRA '93 abolished this concept, the procedure is obsolete. LGHPs that identify mistaken Medicare primary payments should send their repayments to the Medicare contractor that made the mistaken payment.

*Comment:* One commenter expressed concern that if an active individual is covered as a dependent by his spouse's LGHP, and his employer is not large enough for the employer's GHP to be considered an LGHP and the employer does not participate in a multi-employer LGHP, then the order of payment based on the MSP regulations would be the spouse's LGHP as primary payer, Medicare second, and the health plan of the disabled person's employer last. The commenter pointed out that the proposed rule is not in accordance with the normal "coordination of benefits" rules. Under those rules, if the disabled person is still actively employed, his own health plan would be primary and the spouse's health plan would be secondary. The commenter recommended that the MSP rules determine only whether Medicare, or the plan covering the disabled person as an employee, should be primary. In any event, the plan covering the individual as a dependent should be secondary to Medicare. Employers should not be penalized for extending health coverage to dependents.

*Response:* Section 1862(b) of the Act, and the regulations, alter State and private coordination of benefit rules so that GHPs and LGHPs are made primary to Medicare under certain circumstances, regardless of whether the individual is employed or is a dependent. When the health plan of a family member is primary payer under the MSP law, that payer must pay before Medicare even if the coordination of benefits rules established under State law or private contract call for a different order of payment. The Group Coordination of Benefits Model Regulation adopted by the National Association of Insurance Commissioners (NAIC) specifically recognizes that the usual order of payment for dependent and nondependent coverage is reversed under the circumstances described by the commenter. This means that, in the situation described above, the spouse's LGHP pays first if the spouse has coverage by virtue of current

employment status, Medicare second, and the disabled person's employer plan last. However, when the disabled person's health plan coordinates payment with the spouse's LGHP in the way described in the comment, that is, where the disabled person's plan pays primary to the spouse's LGHP, the combined payments of both plans constitute the primary payment to which Medicare payment is secondary. (Further information regarding the model regulation may be obtained by writing to the NAIC, 120 W. 12th St., Kansas City, MO 64105; phone (816) 842-3600.)

*Comment:* One commenter suggested that HCFA should apply the nondiscrimination rules on a prospective basis after the date they are adopted in final form and that HCFA should refrain from initiating any nondiscrimination provision compliance requests until after adoption of the final rules. Another commenter recommended that the final regulations be made effective with plan years that begin at least six months after the date of publication.

*Response:* HCFA does not have the authority to delay enforcement of the nondiscrimination provisions. Section 9319 of OBRA '86, which included the nondiscrimination provision, was effective for items and services furnished on or after January 1, 1987. As indicated in the general notice we published on September 24, 1987 (52 FR 35966), this provision was self-implementing. It did not provide any waiver under which we could delay the effective date.

We will enforce these provisions in accordance with our statutory responsibility. If it is alleged that an LGHP took into account Medicare entitlement on the basis of disability before the effective date of this final rule, we will base our decision on the statute. This final rule will be effective 30 days after publication in accordance with the usual rulemaking procedures.

*Comment:* One commenter suggested that provisions be added to the final regulation to ensure a formal review and appeals procedure before HCFA takes any action adverse to an employer.

*Response:* Sections 411.120 through 411.126 of the new subpart E set forth appeals procedures with respect to any GHP that HCFA has determined to be nonconforming. These sections specify the parties and explain the various steps in the appeals process and the rights of the plans and of the employers and employee organizations that contribute to the plans, including the following:

- How to request a hearing (§ 411.120).

- Provision for on-the-record review or oral hearing (at the request of a party or on the hearing officer's own motion) and the procedures that the hearing officer follows at an oral hearing with respect to notice, prehearing discovery, evidence, subpoenas, etc., and record of the hearing (§ 411.121).

- Timing, content, distribution, and effect of the hearing officer's decision (§ 411.122).

- Administrator's review of the hearing decision, including basis for decision to review, basis for remand, and finality of the review or remand decision (§ 411.124).

- Reopening of determinations or decisions (§ 411.126).

These procedures are very similar to those in effect for other determinations that adversely affect providers or suppliers of Medicare services. We believe that, by making them available before referral to the IRS, we ensure due process.

*Comment:* One commenter encouraged HCFA to adopt a policy of applying "Alternative Dispute Resolution (ADR)" techniques in MSP cases before proceeding with litigation or referrals to the IRS. The commenter contended that such techniques could lead to fairer and more effective implementation of the MSP law than protracted and expensive litigation.

*Response:* The commenter did not identify specifically the techniques of dispute resolution to which he was referring. As indicated above, this final rule provides appeal rights if HCFA determines that a GHP is a nonconforming GHP.

## VIII. Final Rule Provisions that Implement or Reflect Statutory Amendments

### A. Medicare Secondary to GHPs

Redesignated §§ 411.162 and 411.172 and new § 411.204 specify that Medicare benefits are secondary to GHP benefits under specific circumstances that vary depending on the basis for Medicare eligibility or entitlement.

1. Under § 411.172, aged individuals and spouses (entitled on the basis of age), the MSP provision applies—

- For plans of employers of at least 20 employees; and
- For individuals covered "by virtue of current employment status".

2. Under § 411.204, individuals entitled on the basis of disability, the MSP provision applies—

- For plans of employers of at least 100 employees; and
- For individuals covered "by virtue of current employment status".

3. Under § 411.162, individuals eligible or entitled on the basis of ESRD,

the MSP provision applies to employer plans, including retirement plans, regardless of employer size and the individual's employment status.

We note that OBRA '93 changed the coordination of benefits rules for ESRD beneficiaries who are also entitled to Medicare on the basis of age or disability. This change is discussed under section VIII-G of this preamble.

### B. Current Employment Status

New § 411.104 explains the term and sets forth general and special rules.

Under the general rule, an individual is considered to have current employment status if he or she (1) is actively working or (2) is not actively working but meets all of the following conditions:

- Retains employment rights in the industry;
- Has not had his or her employment terminated by the employer, if the employer provides the coverage, or has not had his or her membership in the employee organization terminated, if the employee organization provides the coverage.
- Is not receiving disability payments from an employer for more than 6 months;
- Is not receiving social security disability benefits; and
- Has employment-based GHP coverage that is not COBRA continuation coverage.

Examples of individuals who fall in the second group are teachers, employees who are on furlough or sick leave, and active union members between jobs. Also, self-employed persons are considered to have current employment status only if their annual earnings related to the employer that offers the GHP coverage equal at least the specified statutory amount in section 211(b)(2) of the Act (currently that amount is \$400).

Members of a religious order who have taken a vow of poverty are not considered to have current employment status if the services they perform as members of the order are considered employment solely because the order has elected (under section 3121(r) of the IRC) to have those services considered as employment for social security purposes.<sup>1</sup>

Members of religious orders who have *not* taken a vow of poverty are considered to have current employment status with the religious order if (1) the

<sup>1</sup> This exemption, enacted by OBRA '89 and effective October 1, 1989, was extended by OBRA '93 to cover services furnished before October 1, 1989. Section 3121(r) of the IRC limits election to orders that require their members to take a vow of poverty.

religious order pays FICA taxes on behalf of that member, or (2) the individual is receiving from the religious order cash remuneration for services rendered.

Members of the clergy are considered to have current employment status with a church or other religious organization if the individual is receiving from the church or other religious organization cash remuneration for services rendered.

- Receipt of delayed compensation for work performed in previous time periods does not confer "current employment status" on an individual who is not working.

The new § 411.104 is consistent with Congressional direction regarding the manner in which coverage "by virtue of current employment status" is to be construed.

The first time Congress used the term "current employment" with respect to working aged individuals was in section 2338 of the Deficit Reduction Act of 1984 (DEFRA), Pub. L. 98-369. DEFRA established in the Act a new section 1837(i), which provided for a special Part B enrollment period for individuals "enrolled in a group health plan \* \* \* by reason of the individual's (or the individual's spouse's) current employment \* \* \*". Section 1837(i) expressly referred to individuals who meet "the conditions described in clauses (i) and (iii) of section 1862(b)(3)(A);" that is, working aged individuals and their spouses. In the legislative report that accompanied the DEFRA, the Congress explained what it meant by the term "by reason of current employment:

The use of the phrase "by reason of current employment" was meant to distinguish those persons who are receiving health benefits *based on employment and are actually employed* from those persons who are receiving benefits based on employment, but who are now retired. (Supplemental Report of the Committee on Ways and Means, U.S. House of Representatives on H.R. 4170, Rept. 98-432 Part 2, March 5, 1984, 1662, emphasis added.)

This explanation encompassed individuals for whom Medicare was secondary payer at that time under section 1862(b)(3)(A); that is, individuals who were "employed at the time (the) item or service is furnished."

By distinguishing in the DEFRA legislative report between "persons who are receiving health benefits based on employment" and individuals who are "retired," the Congress demonstrated that it is not concerned about fine distinctions regarding "when" employment-based coverage was earned; that is, whether, for instance,

present coverage of an employed individual is based on a certain number of hours worked, or a certain level of commissions earned, during the preceding months, quarters, or years of employment. Rather, the Congress is only interested in the broad distinction between plan coverage of individuals who have coverage based on "current employment" and plan coverage of those who are retired.

In OBRA '89, the Congress conformed the language of the secondary payer provision to that of the special Part B enrollment provision for working aged individuals. The phrase "by reason of the current employment of the individual (or the individual's spouse)" replaced the phrase "employed at the time (the) item or service is furnished." By eliminating the provision that the individual actually be working when the services were furnished, the Congress made clear its intent that Medicare be secondary payer to employment based coverage in all circumstances except retirement.

The OBRA '93 amendments that substituted "by virtue of current employment status" for "by reason of current employment," and defined the term "current employment status," reinforced Congressional intent in this regard. OBRA '93 (section 13561(e)(1)(H)) added a new section 1862(b)(1)(E)(ii) to the Medicare law, which expressly defines the term "current employment status":

(ii) **CURRENT EMPLOYMENT STATUS DEFINED.**—An individual has "current employment status" with an employer if the individual is an employee, is the employer, or is associated with the employer in a business relationship.

The inclusion of individuals "associated with the employer in a business relationship" (that is, individuals whose relationship to the employer is based on business rather than on work) demonstrates that the Congress intended that the term "current employment status" be given the broadest possible application. It encompasses not only individuals who are actively working but also individuals under contract with the employer whether or not they actually perform services for the employer, such as attorneys on retainer, tradesmen and insurance agents. Also, an independent insurance agent who is licensed to sell insurance for a particular insurance company has "current employment status" with that company by virtue of his "business relationship." If an agent age 65 or older has plan coverage through that company based on this "current employment status", the

coverage is primary to Medicare (unless specific statutory exceptions apply, such as the 20 employee rule) without regard to the extent to which the agent is presently selling policies on behalf of the company. Only when the agent retires (that is, no longer is authorized to sell policies on behalf of the company) would the "business relationship" with the employer be severed. However, Medicare would be the primary payer, if the company imposes earnings thresholds or other requirements for qualifying for health benefits that the agent does not meet based on this "current employment status".

(As provided by OBRA '93, the "current employment status" criterion also applies to the disability MSP provision.)

#### *C. Prohibition against Taking into Account Medicare Entitlement*

This prohibition was imposed by OBRA '86 for the disabled, and extended to ESRD and the aged by OBRA '89. On January 11, 1991, we published a **Federal Register** notice explaining the import of these self-executing provisions.

1. New § 411.102 and redesignated § 411.161 specify that a GHP may not take into account an individual's ESRD-based Medicare eligibility or entitlement during the 18-month coordination of benefits period, which coincides with the first 18 months of eligibility or entitlement.

2. New § 411.102 and redesignated § 411.170 specify that a GHP of an employer of 20 or more employees may not take into account age-based Medicare entitlement of an individual or spouse age 65 or older who is covered (or seeks to be covered) under the plan by virtue of the individual's current employment status with an employer.

3. New §§ 411.102 and 411.200 specify that an LGHP (a plan that includes at least one employer of 100 or more employees) may not take into account the disability-based Medicare entitlement of an individual who is covered (or seeks to be covered) under the plan by virtue of the individual's or a family member's current employment status with an employer.

#### *D. Nondifferentiation in Providing Benefits*

New § 411.102 and redesignated § 411.161 specify that, in providing benefits to individuals with ESRD and those who do not have ESRD, a GHP may not differentiate on the basis of the existence of ESRD, or the need for dialysis, or in any other manner. These sections further provide that plans may

pay benefits secondary to Medicare after the 18-month coordination of benefits period.

#### E. Equal Benefits

New § 411.102 and redesignated § 411.170 specify that, regardless of whether they are entitled to Medicare, individuals and spouses age 65 or older, who are covered under the plan by virtue of current employment status, are entitled to the same plan benefits, under the same conditions, as individuals and spouses under 65. (These limitations, imposed by OBRA '89, were also described in the January 1991 notice referred to above. OBRA '93 imposed the added requirement of plan coverage based on current employment status.)

#### F. Definitions

In § 411.101—

1. The definition of "group health plan" is revised to reflect that plans of governmental employers are included within the meaning of the term. This has always been so but was clarified by OBRA '93. The definition also expressly clarifies that union plans and employee health and welfare fund plans are included as employee organization plans.

2. The definition of "employer" now includes self-employed persons.

3. The definition of "employee" eliminates the "indicator" concept and references the special rules for the self-employed, for members of religious orders, and for delayed compensation, already noted under section VIII-B.

#### G. Coordination of Benefits: Dual Eligibility/Entitlement

New § 411.163 implements the OBRA '93 amendments (sections 13561(c)(2) and (c)(3)) that established special rules for the 18-month coordination of benefits period. These apply to beneficiaries who are eligible for, or entitled to Medicare on the basis of ESRD, and are also entitled on the basis of age or disability.

We consider the OBRA '93 changes to be self-implementing and therefore effective August 10, 1993, the date of enactment. However, a lawsuit was filed in United States District Court for the District of Columbia on May 5, 1995 (*National Medical Care, Inc. v. Shalala*, Civil Action No. 95-0860), challenging implementation of one aspect of these provisions with respect to group health plan retirement coverage.

In what we describe below as the "fourth rule," under OBRA '93, Medicare remains the primary payer if a group health plan was already secondary payer for an individual entitled on the basis of age or disability

when the individual becomes eligible on the basis of end-stage renal disease. Section 411.163(b)(4) reflects this rule. At first HCFA believed, in error, that OBRA '93 required a private plan to become primary payer under these circumstances, but HCFA later corrected its construction of the statute, and issued guidance on April 24, 1995, stating that Medicare remains the primary payer.

On June 6, 1995, the court issued a preliminary injunction order precluding HCFA from implementing its corrected construction for items and services furnished between August 10, 1993 and April 24, 1995, pending the court's decision on the merits. HCFA will modify the rules, if required, based on the final ruling by the court.

Before enactment of OBRA '93, the ESRD MSP provision applied only when the individual was entitled *solely* on the basis of ESRD. For example, if an individual, who retired at age 58 and was covered under a retirement plan through the former employer, developed ESRD at age 60, the retirement plan was primary to Medicare during the first 18 months of ESRD-based eligibility or entitlement. However, if the individual attained age 65 before the end of the 18-month period, the ESRD MSP provision ceased to apply, and Medicare became the primary payer because, upon attaining age 65, the individual became entitled also on the basis of age and no longer met the "solely" requirement.

Similarly, the working aged and disability MSP provisions did not apply to anyone who was eligible for or entitled to Medicare based on ESRD. Therefore, those provisions ceased to apply, and Medicare became the primary payer when an aged or disabled individual became eligible for Medicare based on ESRD. The OBRA '93 amendments rectified these situations. Section 13561(c)(2) provides that the ESRD MSP provision applies in lieu of the working aged and disability MSP provisions when an aged or disabled individual subject to those provisions becomes eligible for Medicare based on ESRD. Thus, the plan must continue to pay primary to Medicare throughout an 18-month ESRD MSP coordination period. Section 13561(c)(3), which removed the word "solely" from the ESRD MSP provision, provides that the ESRD MSP provision remains in effect for the full 18-month period, even if an individual becomes entitled to Medicare based on age or disability during that period. The specific rules, which are set forth in § 411.163 and referenced in § 411.172(g) (for the aged) and § 411.204(b) (for the disabled), are summarized below.

The first rule in § 411.163, governed exclusively by previous law, is that, if the 18-month period ended before August 1993, Medicare is primary payer from the first month of dual eligibility/entitlement.

The second rule, for situations governed partly by previous law and partly by the OBRA '93 amendment, is that if the first month of ESRD-based eligibility or entitlement and the first month of dual eligibility/entitlement both fall after February 1992 and before August 10, 1993, Medicare is—

- Primary payer from the first month of dual eligibility/entitlement through August 9, 1993;
- Secondary payer from August 10, 1993 through the 18th month of ESRD-based eligibility or entitlement; and
- Primary payer again after the 18th month of ESRD-based eligibility or entitlement.

The third rule, for situations governed exclusively by the OBRA '93 amendment, is that, if the first month of ESRD-based eligibility or entitlement is after February 1992, and the first month of dual eligibility or entitlement is after August 9, 1993, Medicare is—

- Secondary during the first 18 months of ESRD-based eligibility or entitlement; and
- Primary after the 18th month of ESRD-based eligibility or entitlement.

The fourth rule pertains to dual entitlement situations in which—

- Age-based or disability-based entitlement precedes ESRD-based eligibility; and
- The GHP was not precluded from taking into account Medicare entitlement based on age or disability (because the individual was not covered under the plan "by virtue of current employment status" or because the employer had fewer than 20 or 100 employees, in the case of the aged and disabled, respectively) and was paying benefits secondary to Medicare.

Medicare eligibility based on ESRD occurs automatically as of the fourth calendar month of dialysis, and earlier under certain circumstances, without regard to whether an individual is already entitled to Medicare based on age or disability.

Under prior law, Medicare benefits were secondary to GHP benefits for a period of 18 months for an individual eligible for or entitled to Medicare based "solely" on ESRD. If that individual also became entitled to Medicare based on age or disability during the 18-month coordination period, Medicare became the primary payer because the ESRD MSP provision did not apply; that is, plans were permitted to take into account ESRD-based entitlement that

was not the *sole* basis of Medicare entitlement.

Also under prior law, Medicare benefits were secondary to plan benefits for certain individuals entitled to Medicare based on age or disability when their plan coverage was based on active employment status, including the employment of a spouse in the case of aged beneficiaries, or the employment of a family member in the case of disabled beneficiaries. If the aged or disabled beneficiary subsequently became eligible for Medicare based on ESRD, Medicare became the primary payer because the working aged and disability MSP provisions stipulated that they did not apply to anyone with ESRD-based eligibility.

The OBRA '93 amendments rectify these situations. However, they do not affect benefit coordination where Medicare is primary and a GHP secondary for reasons wholly unrelated to ESRD. The ESRD MSP provision, as amended by OBRA '93, expressly prohibits plans during the first 18 months of ESRD-based eligibility or entitlement from taking into account Medicare eligibility or entitlement "under section 226A" of the Social Security Act; that is, on the basis of ESRD. Thus, the plain language of the statute permits a plan to pay secondary to Medicare for reasons unrelated to ESRD.

In other words, if prior to the occurrence of ESRD-based eligibility a plan was legitimately secondary to Medicare, the plan clearly was not taking into account ESRD-based eligibility, because a plan could not have taken into account eligibility that did not exist. Merely continuing such authorized action, when an individual becomes eligible based on ESRD, obviously does not take into account the later eligibility or violate the MSP provisions. In sum, the subsequent occurrence of ESRD-based eligibility, in and of itself, does not establish that a GHP is taking that eligibility or entitlement into account.

In contrast, a plan that is paying primary benefits takes into account ESRD-based eligibility if it attempts to shift that primary payment responsibility to Medicare when an individual becomes eligible for Medicare based on ESRD, or when an individual is always eligible for Medicare based on ESRD but has not completed of the 18-month coordination period. (It goes without saying that cessation of plan benefits for reasons that would apply to any plan enrollee, such as an individual's failure to pay plan premiums, would not be construed

as taking into account ESRD-based eligibility.)

In arriving at this synergistic construction of the whole Medicare statute we were mindful that nothing in the legislative history of OBRA '93 indicates that Congress intended the dual entitlement amendments to reverse the order of payment where plans already are permissibly paying benefits secondary to Medicare at the time ESRD-based eligibility or entitlement occurs. In addition, the court in *Blue Cross Blue Shield of Texas v. Shalala*, 995 F.2d 70 (5th Cir. 1993), construed the ESRD MSP provision as not modifying other provisions of law that authorize plan actions. HCFA's construction is consistent with this court decision.

Read together, the OBRA '93 changes require GHPs that are already paying primary to Medicare under the working aged or disability MSP provisions to continue to pay primary to Medicare for a full 18-month coordination period when an aged or disabled individual also becomes eligible for or entitled to Medicare based on ESRD. Similarly, when an individual's ESRD-based eligibility or entitlement is not preceded by age or disability-based entitlement, the plan, including a retirement plan, is obligated to pay primary to Medicare throughout the entire 18-month coordination period.

With respect to retirement plans, the applicability of the ESRD MSP provision has never been limited to plan coverage based on active employment. The OBRA '93 amendments made no change in this regard. Accordingly, when a retirement plan is a primary payer prior to the occurrence of ESRD-based eligibility, the plan must pay primary to Medicare during an 18-month coordination period, even if the individual also becomes entitled to Medicare based on age or disability during that period.

However, as we have stated, when a plan has already permissibly taken into account age or disability-based Medicare entitlement, and does nothing more, the plan is not taking into account subsequently acquired ESRD-based eligibility. Therefore, Medicare remains primary for an aged or disabled individual who subsequently acquired ESRD-based eligibility when Medicare is paying primary because the individual is not covered by virtue of current employment status, or an MSP exemption applies, such as when an employer employs fewer than 20 or 100 employees (in the case of the aged and disabled, respectively).

**Note:** A suit was filed in United States District Court for the District of Columbia on May 5, 1995 (*National Medical Care, Inc. v. Shalala*, Civil Action No. 95-0860), challenging the application of § 411.63 with respect to group health plan retirement coverage. Absent further action by Congress, the court will resolve the matter. HCFA will publish a notice in the **Federal Register** regarding the court's ruling, and will make changes to § 411.63 if required by the court.

New § 411.163 replaces § 411.62(e), Effect of changed basis for Medicare entitlement, which was rendered obsolete by OBRA '93.

#### H. Basis for Primary Payments

New § 411.206 specifies that with respect to the disabled, Medicare is primary payer for services that are not covered under the plan for the disabled or for similarly situated individuals or, although covered under the plan, are not available to particular disabled individuals because they have exhausted their benefits under the plan. (Similar rules for ESRD and aged were already in effect.)

#### I. Interface With COBRA Continuation Coverage Provisions

As a result of the "current employment status" concept established by OBRA '93 for the aged and the disabled and the court rulings in the ESRD case discussed under parts VII-E and VIII-G of this preamble—

1. New § 411.161(a)(3) and redesignated § 411.162(a)(3) specify, respectively, that for ESRD beneficiaries—

- A plan may terminate COBRA continuation coverage of an enrollee who becomes entitled to Medicare if expressly permitted under the COBRA provisions; and

- Medicare benefits are secondary to COBRA continuation benefits only when the plan—

- + Is required (under COBRA) to continue COBRA coverage after Medicare entitlement (applicable to retirees who retired before the employer effectively terminates regular plan coverage by filing for bankruptcy); or
- + Continues coverage voluntarily even though not required to do so under the COBRA provisions.

2. Redesignated § 411.175 and new § 411.206 specify that HCFA makes Medicare primary payments for services furnished to aged individuals and disabled individuals whose benefits are terminated under the COBRA provisions that permit termination upon Medicare entitlement and when benefits are maintained under the COBRA provisions, notwithstanding an individual's Medicare entitlement. (An individual who is eligible for COBRA



continuation coverage because his working hours have been reduced below the minimum necessary to qualify for regular plan coverage has "current employment status". However, Medicare is the primary payer because the plan coverage is not "by virtue of" that status.)

#### *J. Aggregation Rules*

New § 411.106 sets forth the rules established by OBRA '93 for determining the number and size of employers, as required by the "at least 20 employees" provision for the aged and the "at least 100 employees" provision for the disabled.

These rules provide for—

- Treating as a single employer all employers that are so treated under section 53 of the IRC of 1986;
- Treating as employed by a single employer all employees of an affiliated service group, as defined in section 414(m) of the IRC; and
- Treating leased employees as employees of the person for whom they perform services, to the extent provided in section 414(n) of the IRC.

#### *K. Prohibitions Against Incentives*

New § 411.103 reflects the provisions of OBRA '90 (section 4203(g)) and the changes made by section 157(b)(7) (C) and (D) of the SSAA '94 with respect to prohibition of incentives and imposition of civil money penalties for violation. Amended section 1862(b)(3)(C) provides that it is unlawful for an employer or other entity such as an insurer to offer Medicare beneficiaries financial or other benefits as incentives not to enroll in, or to terminate enrollment in, a GHP that is, or would be, primary to Medicare, even if the payments or benefits are offered to all other individuals who are eligible for coverage under the plan. This prohibition precludes offering to Medicare beneficiaries an alternative to the employer's primary plan (for example, coverage of prescription drugs) unless the beneficiary has primary coverage other than Medicare. An example would be primary plan coverage through his own or a spouse's employer. An entity that violates this prohibition is subject to a civil money penalty of up to \$5000 for each violation. Certain provisions of section 1128A of the Act would apply to the civil money penalty.

#### *L. Assessment of Interest*

New paragraph (m) of § 411.24 reflects the additional authority to assess interest provided by SSA '94 and states the rules applicable to interest charges. HCFA has long been authorized under common law and Departmental

regulations (45 CFR 30.13), consistent with the Federal Claims Collection Act (31 U.S.C. 3711), to charge interest on amounts that any responsible party does not timely refund to HCFA. The SSAA '94 (section 151(b)(3)) revised the Medicare law to state specifically that HCFA may charge interest if the responsible party does not refund HCFA within 60 days of the date HCFA receives notice or other information that reimbursement is owed to HCFA. Amended section 1862(b)(2)(B)(i) provides that we may charge interest beginning with the date of that notice or other information. The rate of interest provided in section 1862(b)(2)(B)(i) is the same as in sections 1815(d) and (1833), which is reflected in regulations at 42 CFR 405.376(d). This is also the rate that is charged when HCFA exercises its common law authority.

#### *M. Plan Secondary Payments After 18-Month Coordination of Benefits Period*

Section 411.102(a)(2) reflects the change made by 151(c)(5) of the Social Security Act Amendments of 1994 to limit what a plan may do after the end of the coordination period.

### **IX. Technical Amendments**

#### *A. Nomenclature Changes*

The following are in addition to those described in section VI of this preamble:

1. To conform to the statutory language, "employer plan" and "employer group health plan" are changed to "group health plan".
2. To conform to the new rules that apply in dual eligibility/entitlement situations, the word "solely" is removed from the phrase "entitled solely on the basis of ESRD".

#### *B. Date and Duration Changes*

Various dates cited in paragraphs (c) and (d) of redesignated § 411.162 have been revised to conform to the OBRA '93 amendment that changed to October 1, 1998, the date on which the 18-month ESRD coordination of benefits period is scheduled to revert to a 12-month period.

### **X. Waiver of Proposed Rulemaking**

We ordinarily publish a notice of proposed rulemaking in the **Federal Register** and invite prior public comment on proposed rules. The notice of proposed rulemaking includes a reference to the legal authority under which the rule is proposed and the terms and substance of the proposed rule or a description of the subjects and issues involved. This procedure can be waived, however, if an agency finds good cause that a notice-and-public comment procedure is impracticable,

unnecessary, or contrary to the public interest and incorporates a statement of the finding and its reasons in the rule issued.

The proposed rule of March 1990 dealt only with the provisions of OBRA '86 which pertain to the disabled and to LGHPs that cover them. Under that rule, certain nonworking disabled persons would have been considered employees for Medicare secondary payer purposes. Most of the public comments we received (discussed in section VII of this preamble) objected to that policy.

Under the OBRA '93 amendments discussed in Section IV of this preamble, the MSP provision for the disabled applies only to persons whose health care coverage is based on their own current employment status or the current employment status of a family member. Since the law and the accompanying legislative history made clear that an individual must have "current employment status" for purposes of the MSP provisions, the proposed policy is not included in the final rule.

This final rule also implements the MSP provisions of OBRA '89. The OBRA '89 amendments (discussed under section II-C)—

- Prohibited GHPs from taking into account Medicare entitlement of aged Medicare beneficiaries and the eligibility or entitlement of beneficiaries with ESRD. (Previously, the prohibition against taking into account Medicare entitlement applied only to disabled individuals.)
- Required GHPs of employers of 20 or more employees to provide to employees and spouses age 65 or over the same benefits under the same conditions as they provide to employees and spouses under age 65;
- Prohibited GHPs from differentiating, in the benefits they provide, between individuals with ESRD and other individuals covered under the plan;
- Exempted from the MSP provisions services which members of a religious order who have taken a vow of poverty perform as members of the order; and
- Extended to all MSP situations the Federal Government's rights to take legal action and recover double damages from any entity that is required or responsible to pay primary benefits.

These OBRA '89 amendments were self-implementing and as such were reflected in a notice published on January 11, 1991 (at 56 FR 1200-1202). The notice explained the new requirements and stated that they could be put into effect without issuing regulations because the statutory amendments and the Congressional

intent were clear. Most of the changes were applicable to services furnished on or after December 20, 1989 and are, thus, already in effect.

This final rule includes appeals procedures that were not in the March 1990 proposal for appealing determinations of nonconformance. These provisions, which have been added as a result of comments on the proposed rule and apply to all three MSP situations, include the following:

- The rules under which HCFA determines that a plan is not in conformance.
- The appeals procedures for plans found to be nonconforming.
- Referral to the IRS.
- Rules for recovery of conditional or mistaken payments.

Although notice and comment on the portions of this rule that reflect the self-implementing statutory changes are being waived, we will consider timely comments from anyone who believes that in issuing these regulations we have gone beyond what the statute requires or permits. We also welcome comments on the appeals procedures.

Since the public has already had opportunity to comment on the OBRA '86 amendments, the OBRA '89 amendments were self-executing and went into effect several years ago, and the OBRA '90 and the OBRA '93 amendments and the Social Security Act Amendments of 1994 addressed in these regulations are self-implementing and clear on their face as to Congressional intent, we find that notice and opportunity for comment (except as provided in the preceding paragraph) are unnecessary and that there is good cause to waive notice of proposed rulemaking.

## XI. Public Comments

Although this is a final rule, we will consider comments that we receive by the date and time specified in the DATES section of this preamble. Because of the large number of letters of comment that we generally receive, we cannot respond to them individually. However, if we revise these rules as a result of comments, we will discuss all timely comments in the preamble to the revised rules.

## XII. Paperwork Reduction Act

Sections 411.112 and 411.115 of this rule contain information collection requirements that are subject to review by the Office of Management and Budget under the Paperwork Reduction Act of 1980. Under § 411.112, HCFA may require a GHP to demonstrate that it has complied with the MSP provisions and to submit documentation

showing that it has not taken into account that any of its enrollees is entitled to Medicare on the basis of age or disability or eligible or entitled on the basis of ESRD. The estimated burden is 10 hours per response. Under § 411.115, a plan that has been determined to be nonconforming is required to provide to HCFA the names and addresses of all employers and employee organizations that contributed to the plan during the year for which it was nonconforming. Since this merely requires copies of existing data, the time required is considered negligible.

## XIII. Regulatory Impact Statement

### A. Executive Order 12866

These changes are already in place, and became effective on the statutory dates indicated in the preamble of this rule. The discretionary portions of this regulation will not affect these changes by more than a few million dollars at the margin. Therefore, while the statutory changes will have economic effects in excess of \$100 million, this final rule with comment period is not an economically significant rule under E.O. 12866. In order for the public to understand the magnitude of the statutory changes we have prepared the following voluntary analysis of the effects of these changes on program costs.

#### 1. Current Employment Status

Section 13561(e) of OBRA '93 deletes the concept of "active individual" and applies the MSP disability provision only to individuals who are covered under a large group health plan by reason of their current employment status or that of a family member.

Since disabled persons generally are not working (and therefore do not have current employment status), fewer individuals will be subject to the MSP provisions and Medicare will be primary payer for more disabled beneficiaries. We estimate that the Medicare program will have the following costs as a result of this change.

#### MEDICARE PROGRAM COSTS RESULTING FROM NO LONGER TREATING CERTAIN DISABLED PERSONS AS EMPLOYEES

[In million of dollars]

Fiscal year:	
1995 .....	3
1996 .....	3
1997 .....	2
1998 .....	1
1999 .....	0

#### 2. Dual Eligibility/Entitlement

Before enactment of OBRA '93, if an individual was eligible for or entitled to Medicare on the basis of ESRD and was also entitled on the basis of age or disability, Medicare was the primary payer. This is because the ESRD MSP provision only applied with respect to individuals who were eligible for or entitled to Medicare solely on the basis of ESRD. However, section 13561(c) (2) and (3) of OBRA '93 provides that there will be an 18-month coordination period during which employer sponsored insurance plans must pay primary benefits even if an individual who is eligible for or entitled to Medicare based on ESRD is also entitled to Medicare on another basis.

We estimate that the following savings will accrue to the Medicare program as a result of this change.

#### MEDICARE PROGRAM SAVINGS RESULTING FROM ESRD DUAL ELIGIBILITY PROVISIONS

[In millions of dollars]

Fiscal year:	
1995 .....	71
1996 .....	83
1997 .....	97
1998 .....	114
1999 .....	98

#### 3. IRS Aggregation Rules

The MSP provisions for the working aged apply to employers with 20 or more employees. The MSP provisions for the disabled apply to GHPs contributed to by at least one employer with 100 or more employees. Large employers have been able to avoid having the MSP rules apply to them by simply organizing themselves into small firms. Section 13561(d) of OBRA '93 requires the use of IRS aggregation rules to determine employer size for MSP purposes. Employers treated as single employers under section 52 (a) or (b) of the IRC of 1986 are treated as single employers for purposes of MSP. All employees of the members of an affiliated service group are treated as employed by a single employer. Leased employees (as defined in section 414(m) of the IRC) are treated as employees of the person for whom they perform services to the same extent as they are treated under section 414(n) of the IRC.

We estimate that the following savings will accrue to the Medicare program as a result of this change.

# MEDICARE PROGRAM SAVINGS RESULTING FROM USE OF IRS AGGREGATION RULES TO DETERMINE FIRM SIZE

[in million of dollars]

Fiscal year:	
1995 .....	80
1996 .....	100
1997 .....	115
1998 .....	125
1999 .....	80

In accordance with the provisions of Executive Order 12866, this final rule with comment period was not reviewed by the Office of Management and Budget.

## B. Regulatory Flexibility Analysis

Consistent with the Regulatory Flexibility Act (RFA) and section 1102(b) of the Social Security Act, we prepare a regulatory flexibility analysis for each rule, unless the Secretary certifies that the particular rule will not have a significant economic impact on a substantial number of small entities or a significant impact on the operation of a substantial number of small rural hospitals.

The RFA defines "small entity" as a small business, a nonprofit enterprise, or a governmental jurisdiction (such as a county, city, or township) with a population of less than 50,000. We also consider all providers and suppliers of services to be small entities. For purposes of section 102(b) of the Act, we define small rural hospital as a hospital that has fewer than 50 beds and is located anywhere but in a metropolitan statistical area.

As noted earlier, this rule incorporates changes enacted by various statutes that already are effective. Discretionary portions of the rule are minimal and, of themselves, have no more than an incidental effect. Therefore, we have not prepared a regulatory flexibility analysis because we have determined, and we certify, that these rules will not have a significant economic impact on a substantial number of small entities or a significant impact on the operation of a substantial number of small rural hospitals.

## List of Subjects

### 42 CFR Part 400

Grant programs—health, Health facilities, Health maintenance organizations (HMO), Medicaid, Medicare, Reporting and recordkeeping requirements.

### 42 CFR Part 411

Exclusions from Medicare, Limitations on Medicare payments, Medicare, Recovery against third parties. Reporting and recordkeeping requirements.

42 CFR Chapter IV is amended as set forth below.

## PART 400—INTRODUCTION; DEFINITIONS

A. The authority citation for part 400 continues to read as follows:

**Authority:** Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh) and 44 U.S.C. Chapter 35.

### § 400.310 [Amended]

B. In § 400.310, in the table, "411.65" is revised to read "411.165".

## PART 411—EXCLUSIONS FROM MEDICARE AND LIMITATIONS ON MEDICARE PAYMENT

A. The authority citation for part 411 is revised to read as follows:

**Authority:** Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

B. Subpart A is amended as set forth below.

### Subpart A—General Exclusions and Exclusion of Particular Services

1. Section 411.1 is amended by adding the following sentence at the end of paragraph (a):

#### § 411.1 Basis and scope.

(a) *Statutory basis.* \* \* \* Sections 1842(l) and 1879 of the Act provide for refund to, or indemnification of, a beneficiary who has paid a provider or supplier for certain services that the provider or supplier knew were excluded from Medicare coverage.

\* \* \* \* \*

C. Subpart B is amended as follows:

### Subpart B—Insurance Coverage That Limits Medicare Payment: General Provisions

1. Section 411.20 is revised to read as follows:

#### § 411.20 Basis and scope.

(a) *Statutory basis.*—(1) Section 1862(b)(2)(A)(i) of the Act precludes Medicare payment for services to the extent that payment has been made or can reasonably be expected to be made under a group health plan with respect to—

(i) A beneficiary entitled to Medicare on the basis of ESRD during the first 18 months of that entitlement;

(ii) A beneficiary who is age 65 or over, entitled to Medicare on the basis of age, and covered under the plan by virtue of his or her current employment

status or the current employment status of a spouse of any age; or

(iii) A beneficiary who is under age 65, entitled to Medicare on the basis of disability, and covered under the plan by virtue of his or her current employment status or the current employment status of a family member.

(2) Section 1862(b)(2)(A)(ii) of the Act precludes Medicare payment for services to the extent that payment has been made or can reasonably be expected to be made promptly under any of the following:

(i) Workers' compensation.

(ii) Liability insurance.

(iii) No-fault insurance.

(b) *Scope.* This subpart sets forth general rules that apply to the types of insurance specified in paragraph (a) of this section. Other general rules that apply to group health plans are set forth in subpart E of this part.

### § 411.21 [Amended]

2. In § 411.21, the following changes are made:

(a) The introductory text is revised and a definition of "monthly capitation payment" is added, to read as set forth below.

(b) In the definition of "conditional payment", "for which another insurer is primary payer" is revised to read "for which another payer is responsible", and "subparts C through G" is revised to read "subparts C through H".

### § 411.21 Definitions.

In this subpart B and in subparts C through H of this part, unless the context indicates otherwise—

\* \* \* \* \*

*Monthly capitation payment* means a comprehensive monthly payment that covers all physician services associated with the continuing medical management of a maintenance dialysis patient who dialyses at home or as an outpatient in an approved ESRD facility.

\* \* \* \* \*

3. Section 411.24 is amended to revise paragraph (c) to read as follows:

### § 411.24 Recovery of conditional payments.

\* \* \* \* \*

(c) *Amount of recovery.*—(1) If it is not necessary for HCFA to take legal action to recover, HCFA recovers the lesser of the following:

(i) The amount of the Medicare primary payment.

(ii) The full primary payment amount that the primary payer is obligated to pay under this part without regard to any payment, other than a full primary payment that the primary payer has paid or will make, or, in the case of a

third party payment recipient, the amount of the third party payment.

(2) If it is necessary for HCFA to take legal action to recover from the primary payer, HCFA may recover twice the amount specified in paragraph (c)(1)(i) of this section.

\* \* \* \* \*

4. Section 411.24 is amended by adding a new paragraph (m) to read as follows:

\* \* \* \* \*

(m) *Interest charges.*(1) With respect to recovery of payments for items and services furnished before October 31, 1994, HCFA charges interest, exercising common law authority in accordance with 45 CFR 30.13, consistent with the Federal Claims Collection Act (31 U.S.C. 3711).

(2) In addition to its common law authority with respect to recovery of payments for items and services furnished on or after October 31, 1994, HCFA charges interest in accordance with section 1862(b)(2)(B)(i) of the Act. Under that provision—

(i) HCFA may charge interest if reimbursement is not made to the appropriate trust fund before the expiration of the 60-day period that begins on the date on which notice or other information is received by HCFA that payment has been or could be made under a primary plan;

(ii) Interest may accrue from the date when that notice or other information is received by HCFA and is charged until reimbursement is made; and

(iii) The rate of interest is that provided at 42 CFR 405.376(d).

#### § 411.33 [Amended]

5. In § 411.33, the following changes are made:

a. The heading and introductory text of paragraph (a) are revised to read as set forth below.

b. In paragraph (a)(1), “(or the amount the supplier is obligated to accept as payment in full if that is less than the charges)” is inserted immediately after “the supplier”.

c. In paragraph (a)(3), “Medicare fee schedule,” is inserted before “Medicare reasonable charge” and a comma is inserted after “reasonable charge”.

d. In paragraph (b) introductory text and paragraph (b)(3), “reasonable charge” is revised to read “fee schedule”.

e. Paragraphs (c) and (d) are removed and reserved.

f. In the heading of paragraph (e), “fee schedule,” is inserted before “reasonable charge”, and a comma is inserted after “reasonable charge”.

#### § 411.33 Amount of Medicare secondary payment.

(a) *Services for which HCFA pays on a Medicare fee schedule or reasonable charge basis.* The Medicare secondary payment is the lowest of the following:

\* \* \* \* \*

(c) [Reserved]

(d) [Reserved]

\* \* \* \* \*

D. Subparts E and F are redesignated as subparts F and G, respectively, in accordance with the redesignation tables set forth below, and throughout part 411, internal cross references are revised to reflect these changes.

Old section (subpart E):	New section (subpart F)
411.60 .....	411.160
411.62 .....	411.162
411.65 .....	411.165
Old section (subpart F):	New section (subpart G)
411.70 .....	411.170
411.72 .....	411.172
411.75 .....	411.175

E. A new subpart E is added, to read as follows:

#### Subpart E—Limitations on Payment for Services Covered Under Group Health Plans: General Provisions

Sec.

- 411.100 Basis and scope.
- 411.101 Definitions.
- 411.102 Basic prohibitions and requirements.
- 411.103 Prohibition against financial and other incentives.
- 411.104 Current employment status.
- 411.106 Aggregation rules.
- 411.108 Taking into account entitlement to Medicare.
- 411.110 Basis for determination of nonconformance.
- 411.112 Documentation of conformance.
- 411.114 Determination of nonconformance.
- 411.115 Notice of determination of nonconformance.
- 411.120 Appeals.
- 411.121 Hearing procedures.
- 411.122 Hearing officer's decision.
- 411.124 Administrator's review of hearing decision.
- 411.126 Reopening of determinations and decisions.
- 411.130 Referral to Internal Revenue Service (IRS).

#### Subpart E—Limitations on Payment for Services Covered Under Group Health Plans: General Provisions

##### § 411.100 Basis and scope.

(a) *Statutory basis.*—(1) Section 1862(b) of the Act provides in part that Medicare is secondary payer, under specified conditions, for services covered under any of the following:

(i) Group health plans of employers that employ at least 20 employees and

that cover Medicare beneficiaries age 65 or older who are covered under the plan by virtue of the individual's current employment status with an employer or the current employment status of a spouse of any age. (Section 1862(b)(1)(A))

(ii) Group health plans (without regard to the number of individuals employed and irrespective of current employment status) that cover individuals who have ESRD. Except as provided in § 411.163, group health plans are always primary payers throughout the first 18 months of ESRD-based Medicare eligibility or entitlement. (Section 1862(b)(1)(C))

(iii) Large group health plans (that is, plans of employers that employ at least 100 employees) and that cover Medicare beneficiaries who are under age 65, entitled to Medicare on the basis of disability, and covered under the plan by virtue of the individual's or a family member's current employment status with an employer. (Section 1862(b)(1)(B))

(2) Sections 1862(b)(1) (A), (B), and (C) of the Act provide that group health plans and large group health plans may not take into account that the individuals described in paragraph (a)(1) of this section are entitled to Medicare on the basis of age or disability, or eligible for, or entitled to Medicare on the basis of ESRD.

(3) Section 1862(b)(1)(A)(i)(II) of the Act provides that group health plans of employers of 20 or more employees must provide to any employee or spouse age 65 or older the same benefits, under the same conditions, that it provides to employees and spouses under 65. The requirement applies regardless of whether the individual or spouse 65 or older is entitled to Medicare.

(4) Section 1862(b)(1)(C)(ii) of the Act provides that group health plans may not differentiate in the benefits they provide between individuals who have ESRD and other individuals covered under the plan on the basis of the existence of ESRD, the need for renal dialysis, or in any other manner. Actions that constitute “differentiating” are listed in § 411.161(b).

(b) *Scope.* This subpart sets forth general rules pertinent to—

(1) Medicare payment for services that are covered under a group health plan and are furnished to certain beneficiaries who are entitled on the basis of ESRD, age, or disability.

(2) The prohibition against taking into account Medicare entitlement based on age or disability, or Medicare eligibility or entitlement based on ESRD.

(3) The prohibition against differentiation in benefits between

individuals who have ESRD and other individuals covered under the plan.

(4) The requirement to provide to those 65 or over the same benefits under the same conditions as are provided to those under 65.

(5) The appeals procedures for group health plans that HCFA determines are nonconforming plans.

#### § 411.101 Definitions.

As used in this subpart and in subparts F through H of this part—

*COBRA* stands for Consolidated Omnibus Budget Reconciliation Act of 1985.

*Days* means calendar days.

*Employee* (subject to the special rules in § 411.104) means an individual who—

(1) Is working for an employer; or  
(2) Is not working for an employer but is receiving payments that are subject to FICA taxes, or would be subject to FICA taxes except that the employer is exempt from those taxes under the Internal Revenue Code.

*Employer* means, in addition to individuals (including self-employed persons) and organizations engaged in a trade or business, other entities exempt from income tax such as religious, charitable, and educational institutions, the governments of the United States, the individual States, Puerto Rico, the Virgin Islands, Guam, American Samoa, the Northern Mariana Islands, and the District of Columbia, and the agencies, instrumentalities, and political subdivisions of these governments.

*FICA* stands for the Federal Insurance Contributions Act, the law that imposes social security taxes on employers and employees under section 21 of the Internal Revenue Code.

*Group health plan (GHP)* means any arrangement made by one or more employers or employee organizations to provide health care directly or through other methods such as insurance or reimbursement, to current or former employees, the employer, others associated or formerly associated with the employer in a business relationship, or their families, that—

(1) Is of, or contributed to by, one or more employers or employee organizations.  
(2) If it involves more than one employer or employee organization, provides for common administration.  
(3) Provides substantially the same benefits or the same benefit options to all those enrolled under the arrangement.

The term includes self-insured plans, plans of governmental entities (Federal, State and local), and employee organization plans; that is, union plans,

employee health and welfare funds or other employee organization plans. The term also includes employee-pay-all plans, which are plans under the auspices of one or more employers or employee organizations but which receive no financial contributions from them. The term does not include a plan that is unavailable to employees; for example, a plan only for self-employed persons.

*IRC* stands for Internal Revenue Code.  
*IRS* stands for Internal Revenue Service.

*Large group health plan (LGHP)* means a GHP that covers employees of either—

(1) A single employer or employee organization that employed at least 100 full-time or part-time employees on 50 percent or more of its regular business days during the previous calendar year; or

(2) Two or more employers, or employee organizations, at least one of which employed at least 100 full-time or part-time employees on 50 percent or more of its regular business days during the previous calendar year.

*MSP* stands for Medicare secondary payer.

*Multi-employer plan* means a plan that is sponsored jointly by two or more employers (sometimes called a multiple-employer plan) or by employers and unions (sometimes under the Taft-Hartley law).

*Self-employed person* encompasses consultants, owners of businesses, and directors of corporations, and members of the clergy and religious orders who are paid for their services by a religious body or other entity.

*Similarly situated individual* means—

(1) In the case of employees, other employees enrolled or seeking to enroll in the plan; and

(2) In the case of other categories of individuals, other persons in any of those categories who are enrolled or seeking to enroll in the plan.

#### § 411.102 Basic prohibitions and requirements.

(a) *ESRD*—(1) A group health plan of any size—(i) May not take into account the ESRD-based Medicare eligibility or entitlement of any individual who is covered or seeks to be covered under the plan; and

(ii) May not differentiate in the benefits it provides between individuals with ESRD and other individuals covered under the plan, on the basis of the existence of ESRD, or the need for dialysis, or in any other manner.

(2) The prohibitions of paragraph (a) of this section do not prohibit a plan from paying benefits secondary to

Medicare after the first 18 months of ESRD-based eligibility or entitlement.

(b) *Age*. A GHP of an employer or employee organization of at least 20 employees—

(1) May not take into account the age-based Medicare entitlement of an individual or spouse age 65 or older who is covered (or seeks to be covered) under the plan by virtue of current employment status; and

(2) Must provide, to employees age 65 or older and to spouses age 65 or older of employees of any age, the same benefits under the same conditions as it provides to employees and spouses under age 65.

(c) *Disability*. A GHP of an employer or employee organization of at least 100 employees may not take into account the disability-based Medicare entitlement of any individual who is covered (or seeks to be covered) under the plan by virtue of current employment status.

#### § 411.103 Prohibition against financial and other incentives.

(a) *General rule*. An employer or other entity (for example, an insurer) is prohibited from offering Medicare beneficiaries financial or other benefits as incentives not to enroll in, or to terminate enrollment in, a GHP that is, or would be, primary to Medicare. This prohibition precludes offering to Medicare beneficiaries an alternative to the employer primary plan (for example, coverage of prescription drugs) unless the beneficiary has primary coverage other than Medicare. An example would be primary coverage through his own or a spouse's employer.

(b) *Penalty for violation*.—(1) Any entity that violates the prohibition of paragraph (a) of this section is subject to a civil money penalty of up to \$5,000 for each violation; and

(2) The provisions of section 1128A of the Act (other than subsections (a) and (b)) apply to the civil money penalty of up to \$5,000 in the same manner as the provisions apply to a penalty or proceeding under section 1128A(a).

#### § 411.104 Current employment status.

(a) *General rule*. An individual has current employment status if—

(1) The individual is actively working as an employee, is the employer (including a self-employed person), or is associated with the employer in a business relationship; or

(2) The individual is not actively working and—

(i) Is receiving disability benefits from an employer for up to 6 months (the first 6 months of employer disability benefits are subject to FICA taxes); or

(ii) Retains employment rights in the industry and has not had his employment terminated by the employer, if the employer provides the coverage (or has not had his membership in the employee organization terminated, if the employee organization provides the coverage), is not receiving disability benefits from an employer for more than 6 months, is not receiving disability benefits from Social Security, and has GHP coverage that is not pursuant to COBRA continuation coverage (26 U.S.C. 4980B; 29 U.S.C. 1161–1168; 42 U.S.C. 300bb–1 et seq.). Whether or not the individual is receiving pay during the period of nonwork is not a factor.

(b) *Persons who retain employment rights.* For purposes of paragraph (a)(2) of this section, persons who retain employment rights include but are not limited to—

(1) Persons who are furloughed, temporarily laid off, or who are on sick leave;

(2) Teachers and seasonal workers who normally do not work throughout the year; and

(3) Persons who have health coverage that extends beyond or between active employment periods; for example, based on an hours bank arrangement. (Active union members often have hours bank coverage.)

(c) *Coverage by virtue of current employment status.* An individual has coverage by virtue of current employment status with an employer if—

(1) the individual has GHP or LGHP coverage based on employment, including coverage based on a certain number of hours worked for that employer or a certain level of commissions earned from work for that employer at any time; and

(2) the individual has current employment status with that employer, as defined in paragraph (a) of this section.

(d) *Special rule: Self-employed person.* A self-employed individual is considered to have GHP or LGHP coverage by virtue of current employment status during a particular tax year only if, during the preceding tax year, the individual's net earnings, from work in that year related to the employer that offers the group health coverage, are at least equal to the amount specified in section 211(b)(2) of the Act, which defines "self-employment income" for social security purposes.

(e) *Special Rule: members of religious orders and members of clergy—(1) Members of religious orders who have not taken a vow of poverty.* A member

of a religious order who has *not* taken a vow of poverty is considered to have current employment status with the religious order if—

(a) The religious order pays FICA taxes on behalf of that member; or

(b) The individual is receiving cash remuneration from the religious order.

(2) *Members of religious orders who have taken a vow of poverty.* A member of a religious order whose members are required to take a vow of poverty is not considered to be employed by the order if the services he or she performs as a member of the order are considered employment only because the order elects social security coverage under section 3121(r) of the IRC. This exemption applies retroactively to services performed as a member of the order, beginning with the effective dates of the MSP provisions for the aged and the disabled, respectively. The exemption does not apply to services performed for employers outside of the order.

(3) *Members of the clergy.* A member of the clergy is considered to have current employment status with a church or other religious organization if the individual is receiving cash remuneration from the church or other religious organization for services rendered.

(f) *Special rule: Delayed compensation subject to FICA taxes.* An individual who is not working is not considered an employee solely on the basis of receiving delayed compensation payments for previous periods of work even if those payments are subject to FICA taxes (or would be subject to FICA taxes if the employer were not exempt from paying those taxes). For example, an individual who is not working in 1993 and receives payments subject to FICA taxes for work performed in 1992 is not considered to be an employee in 1993 solely on the basis of receiving those payments.

#### § 411.106 Aggregation rules.

The following rules apply in determining the number and size of employers, as required by the MSP provisions for the aged and disabled:

(a) All employers that are treated as a single employer under subsection (a) or (b) of section 52 of the Internal Revenue Code (IRC) of 1986 (26 U.S.C. 52 (a) and (b)) are treated as a single employer.

(b) All employees of the members of an affiliated service group (as defined in section 414(m) of the IRC (26 U.S.C. 414m)) are treated as employed by a single employer.

(c) Leased employees (as defined in section 414(n)(2) of the IRC (26 U.S.C. 414(n)(2))) are treated as employees of

the person for whom they perform services to the same extent as they are treated under section 414(n) of the IRC.

(d) In applying the IRC provisions identified in this section, HCFA relies upon regulations and decisions of the Secretary of the Treasury respecting those provisions.

#### § 411.108 Taking into account entitlement to Medicare.

(a) *Examples of actions that constitute "taking into account".* Actions by GHPs or LGHPs that constitute taking into account that an individual is entitled to Medicare on the basis of ESRD, age, or disability (or eligible on the basis of ESRD) include, but are not limited to, the following:

(1) Failure to pay primary benefits as required by subparts F, G, and H of this part 411.

(2) Offering coverage that is secondary to Medicare to individuals entitled to Medicare.

(3) Terminating coverage because the individual has become entitled to Medicare, except as permitted under COBRA continuation coverage provisions (26 U.S.C. 4980B(f)(2)(B)(iv); 29 U.S.C. 1162.(2)(D); and 42 U.S.C. 300bb–2.(2)(D)).

(4) In the case of a LGHP, denying or terminating coverage because an individual is entitled to Medicare on the basis of disability without denying or terminating coverage for similarly situated individuals who are not entitled to Medicare on the basis of disability.

(5) Imposing limitations on benefits for a Medicare entitled individual that do not apply to others enrolled in the plan, such as providing less comprehensive health care coverage, excluding benefits, reducing benefits, charging higher deductibles or coinsurance, providing for lower annual or lifetime benefit limits, or more restrictive pre-existing illness limitations.

(6) Charging a Medicare entitled individual higher premiums.

(7) Requiring a Medicare entitled individual to wait longer for coverage to begin.

(8) Paying providers and suppliers no more than the Medicare payment rate for services furnished to a Medicare beneficiary but making payments at a higher rate for the same services to an enrollee who is not entitled to Medicare.

(9) Providing misleading or incomplete information that would have the effect of inducing a Medicare entitled individual to reject the employer plan, thereby making Medicare the primary payer. An example of this would be informing the

beneficiary of the right to accept or reject the employer plan but failing to inform the individual that, if he or she rejects the plan, the plan will not be permitted to provide or pay for secondary benefits.

(10) Including in its health insurance cards, claims forms, or brochures distributed to beneficiaries, providers, and suppliers, instructions to bill Medicare first for services furnished to Medicare beneficiaries without stipulating that such action may be taken only when Medicare is the primary payer.

(11) Refusing to enroll an individual for whom Medicare would be secondary payer, when enrollment is available to similarly situated individuals for whom Medicare would not be secondary payer.

(b) *Permissible actions*—(1) If a GHP or LGHP makes benefit distinctions among various categories of individuals (distinctions unrelated to the fact that the individual is disabled, based, for instance, on length of time employed, occupation, or marital status), the GHP or LGHP may make the same distinctions among the same categories of individuals entitled to Medicare whose plan coverage is based on current employment status. For example, if a GHP or LGHP does not offer coverage to employees who have worked less than one year and who are *not* entitled to Medicare on the basis of disability or age, the GHP or LGHP is not required to offer coverage to employees who have worked less than one year and who are entitled to Medicare on the basis of disability or age.

(2) A GHP or LGHP may pay benefits secondary to Medicare for an aged or disabled beneficiary who has current employment status if the plan coverage is COBRA continuation coverage because of reduced hours of work. Medicare is primary payer for this beneficiary because, although he or she has current employment status, the GHP coverage is by virtue of the COBRA law rather than by virtue of the current employment status.

(3) A GHP may terminate COBRA continuation coverage of an individual who becomes entitled to Medicare on the basis of ESRD, when permitted under the COBRA provisions.

#### **§ 411.110 Basis for determination of nonconformance.**

(a) A “determination of nonconformance” is a HCFA determination that a GHP or LGHP is a nonconforming plan as provided in this section.

(b) HCFA makes a determination of nonconformance for a GHP or LGHP that, at any time during a calendar year,

fails to comply with any of the following statutory provisions:

(1) The prohibition against taking into account that a beneficiary who is covered or seeks to be covered under the plan is entitled to Medicare on the basis of ESRD, age, or disability, or eligible on the basis of ESRD.

(2) The nondifferentiation clause for individuals with ESRD.

(3) The equal benefits clause for the working aged.

(4) The obligation to refund conditional Medicare primary payments.

(c) HCFA may make a determination of nonconformance for a GHP or LGHP that fails to respond to a request for information, or to provide correct information, either voluntarily or in response to a HCFA request, on the plan's primary payment obligation with respect to a given beneficiary, if that failure contributes to either or both of the following:

(1) Medicare erroneously making a primary payment.

(2) A delay or foreclosure of HCFA's ability to recover an erroneous primary payment.

#### **§ 411.112 Documentation of conformance.**

(a) *Acceptable documentation.* HCFA may require a GHP or LGHP to demonstrate that it has complied with the Medicare secondary payer provisions and to submit supporting documentation by an official authorized to act on behalf of the entity, under penalty of perjury. The following are examples of documentation that may be acceptable:

(1) A copy of the employer's plan or policy that specifies the services covered, conditions of coverage, benefit levels and limitations with respect to persons entitled to Medicare on the basis of ESRD, age, or disability as compared to the provisions applicable to other enrollees and potential enrollees.

(2) An explanation of the plan's allegation that it does not owe HCFA any amount HCFA claims the plan owes as repayment for conditional or mistaken Medicare primary payments.

(b) *Lack of acceptable documentation.* If a GHP or LGHP fails to provide acceptable evidence or documentation that it has complied with the MSP prohibitions and requirements set forth in § 411.110, HCFA may make a determination of nonconformance for both the year in which the services were furnished and the year in which the request for information was made.

#### **§ 411.114 Determination of nonconformance.**

(a) *Starting dates for determination of nonconformance.* HCFA's authority to determine nonconformance of GHPs begins on the following dates:

(1) On January 1, 1987 for MSP provisions that affect the disabled.

(2) On December 20, 1989 for MSP provisions that affect ESRD beneficiaries and the working aged.

(3) On August 10, 1993 for failure to refund mistaken Medicare primary payments.

(b) *Special rule for failure to repay.* A GHP that fails to comply with § 411.110 (a)(1), (a)(2), or (a)(3) in a particular year is nonconforming for that year. If, in a subsequent year, that plan fails to repay the resulting mistaken primary payments (in accordance with § 411.110(a)(4)), the plan is also nonconforming for the subsequent year. For example, if a plan paid secondary for the working aged in 1991, that plan was nonconforming for 1991. If in 1994 HCFA identifies mistaken primary payments attributable to the 1991 violation, and the plan refuses to repay, it is also nonconforming for 1994.

#### **§ 411.115 Notice of determination of nonconformance.**

(a) *Notice to the GHP or LGHP*—(1) If HCFA determines that a GHP or an LGHP is nonconforming with respect to a particular calendar year, HCFA mails to the plan written notice of the following:

- (i) The determination.
- (ii) The basis for the determination.
- (iii) The right of the parties to request a hearing.
- (iv) An explanation of the procedure for requesting a hearing.

(v) The tax that may be assessed by the IRS in accordance with section 5000 of the IRC.

(vi) The fact that if none of the parties requests a hearing within 65 days from the date of its notice, the determination is binding on all parties unless it is reopened in accordance with § 411.126.

(2) The notice also states that the plan must, within 30 days from the date on its notice, submit to HCFA the names and addresses of all employers and employee organizations that contributed to the plan during the calendar year for which HCFA has determined nonconformance.

(b) *Notice to contributing employers and employee organizations.* HCFA mails written notice of the determination, including all the information specified in paragraph (a)(1) of this section, to all contributing employers and employee organizations already known to HCFA or identified by



the plan in accordance with paragraph (a)(2) of this section. Employers and employee organizations have 65 days from the date of their notice to request a hearing.

#### § 411.120 Appeals.

(a) *Parties to the determination.* The parties to the determination are HCFA, the GHP or LGHP for which HCFA determined nonconformance, and any employers or employee organizations that contributed to the plan during the calendar year for which HCFA determined nonconformance.

(b) *Request for hearing.*—(1) A party's request for hearing must be in writing (not in facsimile or other electronic medium) and in the manner stipulated in the notice of nonconformance; it must be filed within 65 days from the date on the notice.

(2) The request may include rationale showing why the parties believe that HCFA's determination is incorrect and supporting documentation.

(3) A request is considered filed on the date it is received by the appropriate office, as shown by the receipt date stamped on the request.

#### § 411.121 Hearing procedures.

(a) *Nature of hearing.*—(1) If any of the parties requests a hearing within 65 days from the date on the notice of the determination of nonconformance, the HCFA Administrator appoints a hearing officer.

(2) If no party files a request within the 65-day period, the initial determination of nonconformance is binding upon all parties unless it is reopened in accordance with § 411.126.

(3) If more than one party requests a hearing the hearing officer conducts a single hearing in which all parties may participate.

(4) *On the record review.* Ordinarily, the hearing officer makes a decision based upon review of the data and documents on which HCFA based its determination of nonconformance and any other documentation submitted by any of the parties within 65 days from the date on the notice.

(5) *Oral hearing.* The hearing officer may provide for an oral hearing either on his or her own motion or in response to a party's request if the party demonstrates to the hearing officer's satisfaction that an oral hearing is necessary. Within 30 days of receipt of the request, the hearing officer gives all known parties written notice of the request and whether the request for oral hearing is granted.

(b) *Notice of time and place of oral hearing.* If the hearing officer provides an oral hearing, he or she gives all

known parties written notice of the time and place of the hearing at least 30 days before the scheduled date.

(c) *Prehearing discovery.*—(1) The hearing officer may permit prehearing discovery if it is requested by a party at least 10 days before the scheduled date of the hearing.

(2) If the hearing officer approves the request, he or she—

(i) Provides a reasonable time for inspection and reproduction of documents; and

(ii) In ruling on discovery matters, is guided by the Federal Rules of Civil Procedure. (28 U.S.C.A. Rules 26–37)

(3) The hearing officer's orders on all discovery matters are final.

(d) *Conduct of hearing.* The hearing officer determines the conduct of the hearing, including the order in which the evidence and the allegations are presented.

(e) *Evidence at hearing.*—(1) The hearing officer inquires into the matters at issue and may receive from all parties documentary and other evidence that is pertinent and material, including the testimony of witnesses, and evidence that would be inadmissible in a court of law.

(2) Evidence may be received at any time before the conclusion of the hearing.

(3) The hearing officer gives the parties opportunity for submission and consideration of evidence and arguments and, in ruling on the admissibility of evidence, excludes irrelevant, immaterial, or unduly repetitious evidence.

(4) The hearing officer's ruling on admissibility of evidence is final and not subject to further review.

(f) *Subpoenas.*—(1) The hearing officer may, either on his or her own motion or upon the request of any party, issue subpoenas for either or both of the following if they are reasonably necessary for full presentation of the case:

(i) The attendance and testimony of witnesses.

(ii) The production of books, records, correspondence, papers, or other documents that are relevant and material to any matter at issue.

(2) A party that wishes the issuance of a subpoena must, at least 10 days before the date fixed for the hearing, file with the hearing officer a written request that identifies the witnesses or documents to be produced and describes the address or location in sufficient detail to permit the witnesses or documents to be found.

(3) The request for a subpoena must state the pertinent facts that the party expects to establish by the witnesses or

documents and whether those facts could be established by other evidence without the use of a subpoena.

(4) The hearing officer issues the subpoenas at his or her discretion, and HCFA assumes the cost of the issuance and the fees and mileage of any subpoenaed witness, in accordance with section 205(d) of the Act (42 U.S.C. 405(d)).

(g) *Witnesses.* Witnesses at the hearing testify under oath or affirmation, unless excused by the hearing officer for cause. The hearing officer may examine the witnesses and shall allow the parties to examine and cross-examine witnesses.

(h) *Record of hearing.* A complete record of the proceedings at the hearing is made and transcribed in all cases. It is made available to the parties upon request. The record is not closed until a decision has been issued.

(i) *Sources of hearing officer's authority.* In the conduct of the hearing, the hearing officer complies with all the provisions of title XVIII of the Act and implementing regulations, as well as with HCFA Rulings issued under § 401.108 of this chapter. The hearing officer gives great weight to interpretive rules, general statements of policy, and rules of agency organization, procedure, or practice established by HCFA.

#### § 411.122 Hearing officer's decision.

(a) *Timing.*—(1) If the decision is based on a review of the record, the hearing officer mails the decision to all known parties within 120 days from the date of receipt of the request for hearing.

(2) If the decision is based on an oral hearing, the hearing officer mails the decision to all known parties within 120 days from the conclusion of the hearing.

(b) *Basis, content, and distribution of hearing decision.*—(1) The written decision is based on substantial evidence and contains findings of fact, a statement of reasons, and conclusions of law.

(2) The hearing officer mails a copy of the decision to each of the parties, by certified mail, return receipt requested, and includes a notice that the administrator may review the hearing decision at the request of a party or on his or her own motion.

(c) *Effect of hearing decision.* The hearing officer's decision is the final Departmental decision and is binding upon all parties unless the Administrator chooses to review that decision in accordance with § 411.124 or it is reopened by the hearing officer in accordance with § 411.126.

#### § 411.124 Administrator's review of hearing decision.

(a) *Request for review.* A party's request for review of a hearing officer's

decision must be in writing (not in facsimile or other electronic medium) and must be received by the Administrator within 25 days from the date on the decision.

(b) *Office of the Attorney Advisor responsibility.* The Office of the Attorney Advisor examines the hearing officer's decision, the requests made by any of the parties or HCFA, and any submission made in accordance with the provisions of this section in order to assist the Administrator in deciding whether to review the decision.

(c) *Administrator's discretion.* The Administrator may—

(1) Review or decline to review the hearing officer's decision;

(2) Exercise this discretion on his or her own motion or in response to a request from any of the parties; and

(3) Delegate review responsibility to the Deputy Administrator. (As used in this section, the term "Administrator" includes "Deputy Administrator" if review responsibility has been delegated.)

(d) *Basis for decision to review.* In deciding whether to review a hearing officer's decision, the Administrator considers—

(1) Whether the decision—

(i) Is based on a correct interpretation of law, regulation, or HCFA Ruling;

(ii) Is supported by substantial evidence;

(iii) Presents a significant policy issue having a basis in law and regulations;

(iv) Requires clarification, amplification, or an alternative legal basis for the decision; and

(v) Is within the authority provided by statute, regulation, or HCFA Ruling; and

(2) Whether review may lead to the issuance of a HCFA Ruling or other directive needed to clarify a statute or regulation.

(e) *Notice of decision to review or not to review.* (1) The Administrator gives all parties prompt written notice of his or her decision to review or not to review.

(2) The notice of a decision to review identifies the specific issues the Administrator will consider.

(f) *Response to notice of decision to review.* (1) Within 20 days from the date on a notice of the Administrator's decision to review a hearing officer's decision, any of the parties may file with the Administrator any or all of the following:

(i) Proposed findings and conclusions.

(ii) Supporting views or exceptions to the hearing officer's decision.

(iii) Supporting reasons for the proposed findings and exceptions.

(iv) A rebuttal to another party's request for review or to other

submissions already filed with the Administrator.

(2) The submissions must be limited to the issues the Administrator has decided to review and confined to the record established by the hearing officer.

(3) All communications from the parties concerning a hearing officer's decision being reviewed by the Administrator must be in writing (not in facsimile or other electronic medium) and must include a certification that copies have been sent to all other parties.

(4) The Administrator does not consider any communication that does not meet the requirements of this paragraph.

(g) *Administrator's review decision.*

(1) The Administrator bases his or her decision on the following:

(i) The entire record developed by the hearing officer.

(ii) Any materials submitted in connection with the hearing or under paragraph (f) of this section.

(iii) Generally known facts not subject to reasonable dispute.

(2) The Administrator mails copies of the review decision to all parties within 120 days from the date of the hearing officer's decision.

(3) The Administrator's review decision may affirm, reverse, or modify the hearing decision or may remand the case to the hearing officer.

(h) *Basis and effect of remand.*—(1) *Basis.* The bases for remand do not include the following:

(i) Evidence that existed at the time of the hearing and that was known or could reasonably have been expected to be known.

(ii) A court case that was either not available at the time of the hearing or was decided after the hearing.

(iii) Change of the parties'

representation.

(iv) An alternative legal basis for an issue in dispute.

(2) *Effect of remand.* (i) The Administrator may instruct the hearing officer to take further action with respect to the development of additional facts or new issues or to consider the applicability of laws or regulations other than those considered during the hearing.

(ii) The hearing officer takes the action in accordance with the Administrator's instructions in the remand notice and again issues a decision.

(iii) The Administrator may review or decline to review the hearing officer's remand decision in accordance with the procedures set forth in this section.

(i) *Finality of decision.* The Administrator's review decision, or the

hearing officer's decision following remand, is the final Departmental decision and is binding on all parties unless the Administrator chooses to review the decision in accordance with this section, or the decision is reopened in accordance with § 411.126.

#### **§ 411.126 Reopening of determinations and decisions.**

(a) A determination that a GHP or LGHP is a nonconforming GHP or the decision or revised decision of a hearing officer or of the HCFA Administrator may be reopened within 12 months from the date on the notice of determination or decision or revised decision, for any reason by the entity that issued the determination or decision.

(b) The decision to reopen or not to reopen is not appealable.

#### **§ 411.130 Referral to Internal Revenue Service (IRS).**

(a) *HCFA responsibility.* After HCFA determines that a plan has been a nonconforming GHP in a particular year, it refers its determination to the IRS, but only after the parties have exhausted all HCFA appeal rights with respect to the determination.

(b) *IRS responsibility.* The IRS administers section 5000 of the IRC, which imposes a tax on employers (other than governmental entities) and employee organizations that contribute to a nonconforming GHP. The tax is equal to 25 percent of the employer's or employee organization's expenses, incurred during the calendar year in which the plan is a nonconforming GHP, for each GHP, both conforming and nonconforming, to which the employer or employee organization contributes.

D. Newly designated subpart F is amended as set forth below.

1. The heading, and § 411.160 are revised to read as follows:

#### **Subpart F—Special Rules: Individuals Eligible or Entitled on the Basis of ESRD, Who Are Also Covered Under Group Health Plans**

##### **§ 411.160 Scope.**

This subpart sets forth special rules that apply to individuals who are eligible for, or entitled to, Medicare on the basis of ESRD. (Section 406.13 of this chapter contains the rules for eligibility and entitlement based on ESRD.)

2. A new § 411.161 is added to read as follows:

**§ 411.161 Prohibition against taking into account Medicare eligibility or entitlement or differentiating benefits.**

(a) *Taking into account*—(1) *Basic rule.* A GHP may not take into account that an individual is eligible for or entitled to Medicare benefits on the basis of ESRD during the coordination period specified in § 411.162 (b) and (c). Examples of actions that constitute taking into account Medicare entitlement are listed in § 411.108(a).

(2) *Applicability.* This prohibition applies for ESRD-based Medicare eligibility to the same extent as for ESRD-based Medicare entitlement. An individual who has ESRD but who has not filed an application for entitlement to Medicare on that basis is eligible for Medicare based on ESRD for purposes of paragraphs (b)(2) and (c)(2) through (c)(4) of § 411.162 if the individual meets the other requirements of § 406.13 of this chapter.

(3) *Relation to COBRA continuation coverage.* This rule does not prohibit the termination of GHP coverage under title X of COBRA when termination of that coverage is expressly permitted, upon entitlement to Medicare, under 26 U.S.C. 4980B(f)(2)(B)(iv); 29 U.S.C. 1162.(2)(D); or 42 U.S.C. 300bb–2.(2)(D).<sup>2</sup> (Situations in which Medicare is secondary to COBRA continuation coverage are set forth in § 411.162(a)(3).)

(b) *Nondifferentiation.*—(1) A GHP may not differentiate in the benefits it provides between individuals who have ESRD and others enrolled in the plan, on the basis of the existence of ESRD, or the need for renal dialysis, or in any other manner.

(2) GHP actions that constitute differentiation in plan benefits (and that may also constitute “taking into account” Medicare eligibility or entitlement) include, but are not limited to the following:

(i) Terminating coverage of individuals with ESRD, when there is no basis for such termination unrelated to ESRD (such as failure to pay plan premiums) that would result in

termination for individuals who do not have ESRD.

(ii) Imposing on persons who have ESRD, but not on others enrolled in the plan, benefit limitations such as less comprehensive health plan coverage, reductions in benefits, exclusions of benefits, a higher deductible or coinsurance, a longer waiting period, a lower annual or lifetime benefit limit, or more restrictive preexisting illness limitations.

(iii) Charging individuals with ESRD higher premiums.

(iv) Paying providers and suppliers less for services furnished to individuals who have ESRD than for the same services furnished to those who do not have ESRD, such as paying 80 percent of the Medicare rate for renal dialysis on behalf of a plan enrollee who has ESRD and the usual, reasonable and customary charge for renal dialysis on behalf of an enrollee who does not have ESRD.

(v) Failure to cover routine maintenance dialysis or kidney transplants, when a plan covers other dialysis services or other organ transplants.

(c) *Uniform Limitations on particular services permissible.* A plan is not prohibited from limiting covered utilization of a particular service as long as the limitation applies uniformly to all plan enrollees. For instance, if a plan limits its coverage of renal dialysis sessions to 30 per year for all plan enrollees, the plan would not be differentiating in the benefits it provides between plan enrollees who have ESRD and those who do not.

(d) *Benefits secondary to Medicare.* (1) The prohibition against differentiation of benefits does not preclude a plan from paying benefits secondary to Medicare after the expiration of the coordination period described in § 411.162 (b) and (c), but a plan may not otherwise differentiate, as described in paragraph (b) of this section, in the benefits it provides.

(2) Example—

Mr. Smith works for employer A, and he and his wife are covered through employer A's GHP (Plan A). Neither is eligible for Medicare nor has ESRD. Mrs. Smith works for employer B, and is also covered by employer B's plan (Plan B). Plan A is more comprehensive than Plan B and covers certain items and services which Plan B does not cover, such as prescription drugs. If Mrs. Smith obtains a medical service, Plan B pays primary and Plan A pays secondary. That is, Plan A covers Plan B copayment amounts and items and services that Plan A covers but that Plan B does not.

Mr. Jones also works for employer A, and he and his wife are covered by Plan A. Mrs. Jones does not have other GHP coverage. Mrs.

Jones develops ESRD and becomes entitled to Medicare on that basis. Plan A pays primary to Medicare during the first 18 months of Medicare entitlement based on ESRD. When Medicare becomes the primary payer, the plan converts Mrs. Jones' coverage to a Medicare supplement policy. That policy pays Medicare deductible and coinsurance amounts but does not pay for items and services not covered by Medicare, which plan A would have covered. That conversion is impermissible because the plan is providing a lower level of coverage for Mrs. Jones, who has ESRD, than it provides for Mrs. Smith, who does not. In other words, if Plan A pays secondary to primary payers other than Medicare, it must provide the same level of secondary benefits when Medicare is primary in order to comply with the nondifferentiation provision.

**§ 411.162 [Amended]**

3. In newly designated § 411.162, the following changes are made:

a. The section heading and paragraph (a) are revised to read as set forth below.

b. In the following paragraphs, “solely” is removed:

Paragraphs (b)(2)(i), (b)(2)(ii), (c)(2)(iii), (c)(2)(iv), (c)(3)(i), (c)(3)(ii), (c)(4)(i), (c)(4)(ii), and (f).

c. In the following paragraphs, “employer plan” and “employer group health plan” are revised to read “group health plan”: The section heading and paragraphs (a)(1), (a)(2)(i)(A), (a)(2)(i)(B), (a)(2)(i)(C), (a)(2)(ii), (d)(7), (d)(8), and (d)(9).

d. In paragraphs (c)(2)(iii) and (c)(2)(iv), “January 1995” is revised to read “September 1997”.

e. In paragraphs (c)(3)(i) and (c)(3)(ii), “July 1994” is revised to read “April 1997”.

f. In paragraph (c)(4), introductory text, “January 1, 1996” is revised to read “September 30, 1998”.

g. In paragraphs (c)(4)(i) and (c)(4)(ii), “August 1994 through January 1, 1995” is revised to read “May 1997 through September 1997”.

h. In paragraph (d)(9), “January 1, 1995” is revised to read “December 1, 1997”; “January 1, 1995 through January 1, 1996, a period of 12 months plus 1 day.” is revised to read “December 1, 1997 through November 30, 1998, a period of 12 months.”; “January 2, 1996” is revised to read “December 1, 1998” and “on or before January 1, 1996” is revised to read “before October 1, 1998”.

i. In paragraph (d)(10), “September 1, 1995” is revised to read “August 1, 1997”; “September 1, 1995 through August 31, 1996” is revised to read “August 1, 1997 through September 30, 1998”; “September 1, 1996” is revised to read October 1, 1998”; and “12 months” is revised to read “14 months”.

j. Paragraph (e) is removed and reserved.

<sup>2</sup> COBRA requires that certain group health plans offer continuation of plan coverage for 18 to 36 months after the occurrence of certain “qualifying events,” including loss of employment or reduction of employment hours. Those are events that otherwise would result in loss of group health plan coverage unless the individual is given the opportunity to elect, and does so elect, to continue plan coverage at his or her own expense. With one exception, the COBRA amendments expressly permit termination of continuation coverage upon entitlement to Medicare. The exception is that the plan may not terminate continuation coverage of an individual (and his or her qualified dependents) if the individual retires on or before the date the employer substantially eliminates regular plan coverage by filing for Chapter 11 bankruptcy (26 U.S.C. 4980B(g)(1)(D) and 29 U.S.C. 1167.(3)(C)).

**§ 411.162 Medicare benefits secondary to group health plan benefits.**

(a) *General provisions*—(1) *Basic rule.* Except as provided in § 411.163 (with respect to certain individuals who are also entitled on the basis of age or disability), Medicare is secondary to any GHP (including a retirement plan), with respect to benefits that are payable to an individual who is entitled to Medicare on the basis of ESRD, for services furnished during any coordination period determined in accordance with paragraphs (b) and (c) of this section. (No Medicare benefits are payable on behalf of an individual who is eligible but not yet entitled.)

(2) *Medicare benefits secondary without regard to size of employer and beneficiary's employment status.* The size of employer and employment status requirements of the MSP provisions for the aged and disabled do not apply with respect to ESRD beneficiaries.

(3) *COBRA continuation coverage.* Medicare is secondary payer for benefits that a GHP—

(i) Is required to keep in effect under COBRA continuation requirements (as explained in the footnote to § 411.161(a)(3)), even after the individual becomes entitled to Medicare; or

(ii) Voluntarily keeps in effect after the individual becomes entitled to Medicare on the basis of ESRD, even though not obligated to do so under the COBRA provisions.

(4) *Medicare payments during the coordination period.* During the coordination period, HCFA makes Medicare payments as follows:

(i) Primary payments only for Medicare covered services that are—

(A) Furnished to Medicare beneficiaries who have declined to enroll in the GHP;

(B) Not covered under the plan;<sup>3</sup>

(C) Covered under the plan but not available to particular enrollees because they have exhausted their benefits; or

(D) Furnished to individuals whose COBRA continuation coverage has been terminated because of the individual's Medicare entitlement.

(ii) Secondary payments, within the limits specified in §§ 411.32 and 411.33, to supplement the amount paid by the GHP if that plan pays only a portion of the charge for the services.

\* \* \* \* \*

(e) [Reserved]

\* \* \* \* \*

4. A new § 411.163 is added, to read as follows:

<sup>3</sup> HCFA does not pay if noncoverage of services constitutes differentiation as prohibited by § 411.161(b).

**§ 411.163 Coordination of benefits: Dual entitlement situations.**

(a) *Basic rule.* Coordination of benefits is governed by this section if an individual is eligible for or entitled to Medicare on the basis of ESRD and also entitled on the basis of age or disability.

(b) *Specific rules*<sup>4</sup>—(1) *Coordination period ended before August 1993.* If the first 18 months of ESRD-based eligibility or entitlement ended before August 1993, Medicare was primary payer from the first month of dual eligibility or entitlement, regardless of when dual eligibility or entitlement began.

(2) *First month of ESRD-based eligibility or entitlement and first month of dual eligibility/entitlement after February 1992 and before August 10, 1993.* If the first month of ESRD-based eligibility or entitlement and first month of dual eligibility/entitlement were after February 1992 and before August 10, 1993, Medicare—

(i) Is primary payer from the first month of dual eligibility/entitlement through August 9, 1993;

(ii) Is secondary payer from August 10, 1993, through the 18th month of ESRD-based eligibility or entitlement; and

(iii) Again becomes primary payer after the 18th month of ESRD-based eligibility or entitlement.

(3) *First month of ESRD-based eligibility or entitlement after February 1992 and first month of dual eligibility/entitlement after August 9, 1993.* If the first month of ESRD-based eligibility or entitlement is after February 1992, and the first month of dual eligibility/entitlement is after August 9, 1993, the rules of § 411.162 (b) and (c) apply; that is, Medicare—

(i) Is secondary payer during the first 18 months of ESRD-based eligibility or entitlement; and

(ii) Becomes primary after the 18th month of ESRD-based eligibility or entitlement.

(4) *Medicare continues to be primary after an aged or disabled beneficiary becomes eligible on the basis of ESRD.*—

(i) *Applicability of the rule.* Medicare remains the primary payer when an individual becomes eligible for

<sup>4</sup> A lawsuit was filed in United States District Court for the District of Columbia on May 5, 1995 (*National Medical Care, Inc. v. Shalala*, Civil Action No. 95-0860), challenging the implementation of one aspect of the OBRA '93 provisions with respect to group health plan retirement coverage. The court issued a preliminary injunction order on June 6, 1995, which enjoins the Secretary from applying the rule contained in § 411.163(b)(4) for items and services furnished between August 10, 1993 and April 24, 1995, pending the court's decision on the merits. HCFA will modify the rules, if required, based on the final ruling by the court.

Medicare based on ESRD if all of the following conditions are met:

(A) The individual is already entitled on the basis of age or disability when he or she becomes eligible on the basis of ESRD.

(B) The MSP prohibition against "taking into account" age-based or disability-based entitlement does not apply because plan coverage was not "by virtue of current employment status" or the employer had fewer than 20 employees (in the case of the aged) or fewer than 100 employees (in the case of the disabled).

(C) The plan is paying secondary to Medicare because the plan had justifiably taken into account the age-based or disability-based entitlement.

(ii) *Effect of the rule.* The plan may continue to pay benefits secondary to Medicare under paragraph (b)(4)(i) of this section. However, the plan may not differentiate in the services covered and the payments made between persons who have ESRD and those who do not.

(c) *Examples.* (1) (Rule (b)(1).) Mr. A, who is covered by a GHP, became entitled to Medicare on the basis of ESRD in January 1992. On December 20, 1992, Mr. A attained age 65 and became entitled on the basis of age. Since prior law was still in effect (OBRA '93 amendment was effective in August 1993), Medicare became primary payer as of December 1992, when dual entitlement began.

(2) (Rule (b)(2).) Miss B, who has GHP coverage, became entitled to Medicare on the basis of ESRD in July 1992, and also entitled on the basis of disability in June 1993. Medicare was primary payer from June 1993 through August 9, 1993, because the plan permissibly took into account the ESRD-based entitlement (ESRD was not the "sole" basis of Medicare entitlement); secondary payer from August 10, 1993, through December 1993, the 18th month of ESRD-based entitlement (the plan is no longer permitted to take into account ESRD-based entitlement that is not the "sole" basis of Medicare entitlement); and again became primary payer beginning January 1994.

(3) (Rule (b)(3).) Mr. C, who is 67 years old and entitled to Medicare on the basis of age, has GHP coverage by virtue of current employment status. Mr. C is diagnosed as having ESRD and begins a course of maintenance dialysis on June 27, 1993. Effective September 1, 1993, Mr. C. is eligible for Medicare on the basis of ESRD. Medicare, which was secondary because Mr. C's GHP coverage was by virtue of current employment, continues to be secondary payer through February 1995, the 18th month of ESRD-based eligibility, and

becomes primary payer beginning March 1995.

(4) (Rule (b)(3).) Mr. D retired at age 62 and maintained GHP coverage as a retiree. In January 1994, at the age of 64, Mr. D became entitled to Medicare based on ESRD. Seven months into the 18-month coordination period (July 1994) Mr. D turned age 65. The coordination period continues without regard to age-based entitlement, with the retirement plan continuing to pay primary benefits through June 1995, the 18th month of ESRD-based entitlement. Thereafter, Medicare becomes the primary payer.

(5) (Rule (b)(3).) Mrs. E retired at age 62 and maintained GHP coverage as a retiree. In July 1994, she simultaneously became eligible for Medicare based on ESRD (maintenance dialysis began in April 1994) and entitled based on age. The retirement plan must pay benefits primary to Medicare from July 1994 through December 1995, the first 18 months of ESRD-based eligibility. Thereafter, Medicare becomes the primary payer.

(6) (Rule (b)(3).) Mr. F, who is 67 years of age, is working and has GHP coverage because of his employment status, subsequently develops ESRD, and begins a course of maintenance dialysis in October 1994. He becomes eligible for Medicare based on ESRD effective January 1, 1995. Under the working aged provision, the plan continues to pay primary to Medicare through December 1994. On January 1, 1995, the working aged provision ceases to apply and the ESRD MSP provision takes effect. In September 1995, Mr. F retires. The GHP must ignore Mr. F's retirement status and continue to pay primary to Medicare through June 1996, the end of the 18-month coordination period.

(7) (Rule (b)(4).) Mrs. G, who is 67 years of age, is retired. She has GHP retirement coverage through her former employer. Her plan permissibly took into account her age-based Medicare entitlement when she retired and is paying benefits secondary to Medicare. Mrs. G subsequently develops ESRD and begins a course of maintenance dialysis in October 1995. She automatically becomes eligible for Medicare based on ESRD effective January 1, 1996. The plan continues to be secondary on the basis of Mrs. G's age-based entitlement as long as the plan does not differentiate in the services it provides to Mrs. G and does not do anything else that would constitute "taking into account" her ESRD-based eligibility.

#### § 411.165 [Amended]

5. In newly designated § 411.165, the following changes are made:

(a) In paragraph (a) the superscript in the heading and the corresponding footnote are removed.

(b) In paragraphs (a)(1), (b)(1)(i), (b)(1)(ii) and (b)(2), "employer plan" is revised to read "group health plan".

E. Newly designated subpart G is amended as set forth below.

1. The heading is revised to read as follows:

#### Subpart G—Special Rules: Aged Beneficiaries and Spouses Who Are Also Covered Under Group Health Plans

##### 2. Nomenclature changes.

(a) In the following locations, "an employer plan" and "an employer group health plan" are revised to read "a group health plan":

§ 411.172 section heading and paragraphs (c).

§ 411.172(d) introductory text and (e).

§ 411.175(b)(1), (c)(1)(i), (c)(1)(iii) and (c)(2).

(b) In § 411.172(d), introductory text, "by reason of employment" is revised to read "by virtue of current employment".

3. Section 411.170 is amended to revise paragraph (a), remove and reserve paragraph (b), and remove paragraphs (d) through (f) to read as follows:

#### § 411.170 General provisions.

(a) *Basis.* (1) This subpart is based on certain provisions of section 1862(b) of the Act, which impose specific requirements and limitations with respect to—

(i) Individuals who are entitled to Medicare on the basis of age; and

(ii) GHPs of at least one employer of 20 or more employees that cover those individuals.

(2) Under these provisions, the following rules apply:

(i) An employer is considered to employ 20 or more employees if the employer has 20 or more employees for each working day in each of 20 or more calendar weeks in the current calendar year or the preceding calendar year.

(ii) The plan may not take into account the Medicare entitlement of—

(A) An individual age 65 or older who is covered or seeks to be covered under the plan by virtue of current employment status; or

(B) The spouse, including divorced or common-law spouse age 65 or older of an individual (of any age) who is covered or seeks to be covered by virtue of current employment status. (Section 411.108 gives examples of actions that constitute "taking into account.")

(iii) Regardless of whether entitled to Medicare, employees and spouses age 65 or older, including divorced or common-law spouses of employees of any age, are entitled to the same plan benefits under the same conditions as employees and spouses under age 65.

(b) [Reserved]

\* \* \* \* \*

(d) through (e) [Removed]

4. Newly designated 411.172 is amended to revise paragraphs (a), (b), and (d) and add a new paragraph (g) to read as follows:

#### § 411.172 Medicare benefits secondary to group health plan benefits.

(a) *Conditions that the individual must meet.* Medicare Part A and Part B benefits are secondary to benefits payable by a GHP for services furnished during any month in which the individual—

(1) Is aged;

(2) Is entitled to Medicare Part A benefits under § 406.10 of this chapter; and

(3) Meets one of the following conditions:

(i) Is covered under a GHP of an employer that has at least 20 employees (including a multi-employer plan in which at least one of the participating employers meets that condition), and coverage under the plan is by virtue of the individual's current employment status.

(ii) Is the aged spouse (including a divorced or common-law spouse) of an individual (of any age) who is covered under a GHP described in paragraph (a)(3)(i) of this section by virtue of the individual's current employment status.

(b) *Special rule for multi-employer plans.* The requirements and limitations of paragraph (a) of this section do not apply with respect to individuals enrolled in a multi-employer plan if—

(1) The individuals are covered by virtue of current employment status with an employer that has fewer than 20 employees; and

(2) The plan requests an exception and identifies the individuals for whom it requests the exception as meeting the conditions specified in paragraph (b)(1) of this section.

\* \* \* \* \*

(d) *Reemployed retiree or annuitant.* A reemployed retiree or annuitant who is covered by a GHP and who performs sufficient services to qualify for coverage on that basis (that is, other employees in the same category are provided health benefits) is considered covered "by reason of current employment status" even if:

(1) The employer provides the same GHP coverage to retirees; or

(2) The premiums for the plan are paid from a retirement or pension fund.

\* \* \* \* \*

(g) *Individuals entitled to Medicare on the basis of age who are also eligible for or entitled to Medicare on the basis of ESRD.* If an aged individual is, or could upon filing an application become, entitled to Medicare on the basis of ESRD, the coordination of benefits rules of subpart F of this part apply.

5. Newly designated § 411.175 is amended to revise paragraph (a), the headings of paragraphs (b) and (c), and paragraph (c)(1)(iii) to read as follows:

**§ 411.175 Basis for Medicare primary payments.**

(a) *General rule.* HCFA makes Medicare primary payments for covered services that are—

(1) Furnished to Medicare beneficiaries who have declined to enroll in the LGHP;

(2) Not covered by the plan for any individuals or spouses who are enrolled by virtue of the individual's current employment status;

(3) Covered under the plan but not available to particular individuals or spouses enrolled by virtue of current employment status because they have exhausted their benefits under the plan;

(4) Furnished to individuals whose COBRA continuation coverage has been terminated because of the individual's Medicare entitlement; or

(5) Covered under COBRA continuation coverage notwithstanding the individual's Medicare entitlement.

\* \* \* \* \*

(b) *Conditional Medicare payments: Basic rule.* \* \* \*

(c) *Conditional primary payments: Exception.* \* \* \*

(1) \* \* \*

(iii) The plan covers the services for individuals or spouses who are enrolled in the plan by virtue of current employment status and are under age 65 but not for individuals and spouses who are enrolled on the same basis but are age 65 or older.

\* \* \* \* \*

F. A new subpart H is added, to read as set forth below.

**Subpart H—Special Rules: Disabled Beneficiaries Who Are Also Covered Under Large Group Health Plans**

Sec.

411.200 Basis.

411.201 Definitions.

411.204 Medicare benefits secondary to LGHP benefits.

411.206 Basis for Medicare primary payments and limits on secondary payments.

**Subpart H—Special Rules: Disabled Beneficiaries Who Are Also Covered Under Large Group Health Plans**

**§ 411.200 Basis.**

(a) This subpart is based on certain provisions of section 1862(b) of the Act, which impose specific requirements and limitations with respect to—

(1) Individuals who are entitled to Medicare on the basis of disability; and

(2) Large group health plans (LGHPs) that cover those individuals.

(b) Under these provisions, the LGHP may not take into account the Medicare entitlement of a disabled individual who is covered (or seeks to be covered) under the plan by virtue of his or her own current employment status or that of a member of his or her family. (§ 411.108 gives examples of actions that constitute taking into account.)

**§ 411.201 Definitions.**

As used in this subpart—

*Entitled to Medicare on the basis of disability* means entitled or deemed entitled on the basis of entitlement to social security disability benefits or railroad retirement disability benefits. (Section 406.12 of this chapter explains the requirements an individual must meet in order to be entitled or deemed to be entitled to Medicare on the basis of disability.)

*Family member* means a person who is enrolled in an LGHP based on another person's enrollment; for example, the enrollment of the named insured individual. Family members may include a spouse (including a divorced or common-law spouse), a natural, adopted, foster, or stepchild, a parent, or a sibling.

**§ 411.204 Medicare benefits secondary to LGHP benefits.**

(a) Medicare benefits are secondary to benefits payable by an LGHP for services furnished during any month in which the individual—

(1) Is entitled to Medicare Part A benefits under § 406.12 of this chapter;

(2) Is covered under an LGHP; and

(3) Has LGHP coverage by virtue of his or her own or a family member's current employment status.

(b) *Individuals entitled to Medicare on the basis of disability who are also eligible for, or entitled to, Medicare on the basis of ESRD.* If a disabled individual is, or could upon filing an application become, entitled to Medicare on the basis of ESRD, the coordination of benefits rules of subpart F of this part apply.

**§ 411.206 Basis for Medicare primary payments and limits on secondary payments.**

(a) *General rule.* HCFA makes Medicare primary payments for services furnished to disabled beneficiaries covered under the LGHP by virtue of their own or a family member's current employment status if the services are—

(1) Furnished to Medicare beneficiaries who have declined to enroll in the LGHP;

(2) Not covered under the plan for the disabled individual or similarly situated individuals;

(3) Covered under the plan but not available to particular disabled individuals because they have exhausted their benefits under the plan;

(4) Furnished to individuals whose COBRA continuation coverage has been terminated because of the individual's Medicare entitlement; or

(5) Covered under COBRA continuation coverage notwithstanding the individual's Medicare entitlement.

(b) *Conditional primary payments: Basic rule.* Except as provided in paragraph (c) of this section, HCFA may make a conditional Medicare primary payment for any of the following reasons:

(1) The beneficiary, the provider, or the supplier that has accepted assignment has filed a proper claim with the LGHP and the LGHP has denied the claim in whole or in part.

(2) The beneficiary, because of physical or mental incapacity, failed to file a proper claim.

(c) *Conditional primary payments: Exceptions.* HCFA does not make conditional Medicare primary payments if—

(1) The LGHP denies the claim in whole or in part for one of the following reasons:

(i) It is alleged that the LGHP is secondary to Medicare.

(ii) The LGHP limits its payments when the individual is entitled to Medicare.

(iii) The LGHP does not provide the benefits to individuals who are entitled to Medicare on the basis of disability and covered under the plan by virtue of current employment status but does provide the benefits to other similarly situated individuals enrolled in the plan.

(iv) The LGHP takes into account entitlement to Medicare in any other way.

(v) There was failure to file a proper claim for any reason other than physical or mental incapacity of the beneficiary.

(2) The LGHP, an employer or employee organization, or the beneficiary fails to furnish information

that is requested by HCFA and that is necessary to determine whether the LGHP is primary to Medicare.

(d) *Limit on secondary payments.* The provisions of § 411.172(e) also apply to services furnished to the disabled under this subpart.

(Catalog of Federal Domestic Assistance Program No. 93.773, Medicare—Hospital Insurance; and Program No. 93.774, Medicare—Supplementary Medical Insurance Program)

Dated: July 12, 1995.

**Bruce C. Vladeck,**

*Administrator, Health Care Financing Administration.*

[FR Doc. 95-21265 Filed 8-30-95; 8:45 am]

BILLING CODE 4120-01-P

## 42 CFR Part 417

[OMC-022-F]

### Full Reporting by Health Maintenance Organizations (HMOs) and Competitive Medical Plans (CMPs) Paid on a Cost Basis

**AGENCY :** Health Care Financing Administration (HCFA), HHS.

**ACTION :** Correction notice.

**SUMMARY:** **Federal Register** document No. 95-16411, beginning on page 34885 of the issue of July 5, 1995 amended part 417 of the HCFA regulations to require full reporting by HMOs and CMPs of the costs of all services furnished to their Medicare enrollees. In that final rule we amended § 417.546 to remove paragraph (b). However, we failed to remove, from the introductory text of the section, a reference to the paragraph (b) that we removed. This notice corrects our oversight.

**EFFECTIVE DATE:** August 4, 1995.

**FOR FURTHER INFORMATION CONTACT:** Luisa V. Iglesias, (202) 690-6383

### Correction

On page 34887, column 3, the amendment to § 417.546 is corrected to read as follows:

3. In § 417.546, the following changes are made:

a. Paragraph (b) and the Editorial note are removed.

b. In paragraph (a), "Except as specified in paragraph (b) of this section," is removed; "the" preceding "amount paid" is revised to read "The"; the "(a)" designation is removed; and the "(1)" and "(2)" designations are revised to read "(a)" and "(b)", respectively.

(Catalog of Federal Domestic Assistance Program No. 13773, Medicare—Hospital Insurance; Program No. 13.774, Medicare—Supplementary Medical Insurance)

Dated: August 22, 1995.

**Neil J. Stillman,**

*Deputy Assistant Secretary for Information Resources Management.*

[FR Doc. 95-21542 Filed 8-30-95; 8:45 am]

BILLING CODE 4120-01-P

## DEPARTMENT OF THE INTERIOR

### Bureau of Land Management

#### 43 CFR Public Land Order 7157

[ID-943-1430-01; IDI-08955-01, IDI-08932-02, IDI-14647-02]

#### Partial Revocation of Public Land Order Nos. 1992 and 2588, and Bureau of Land Management Order Dated January 28, 1952; Idaho

**AGENCY:** Bureau of Land Management, Interior.

**ACTION:** Public land order.

**SUMMARY:** This order revokes two public land orders and one Bureau of Land Management order insofar as they affect 4,522.17 acres of public lands withdrawn for the Bureau of Reclamation's Snake River and Mountain Home Reclamation Projects. The lands are no longer needed for this purpose, and the revocation is needed to permit disposal of the lands through sale and exchange. This action will open the lands to surface entry and mining. The lands have been and will remain open to mineral leasing.

**EFFECTIVE DATE:** October 2, 1995.

**FOR FURTHER INFORMATION CONTACT:** Larry R. Lievsay, BLM Idaho State Office, 3380 Americana Terrace, Boise, Idaho 83706-2500, 208-384-3166.

By virtue of the authority vested in the Secretary of the Interior by Section 204 of the Federal Land Policy and Management Act of 1976, 43 U.S.C. 1714 (1988), it is ordered as follows:

1. Public Land Order No. 1992, which withdrew public lands for the Bureau of Reclamation's Snake River project, is hereby revoked insofar as it affects the following described lands:

#### Boise Meridian

T. 5 S., R. 3 E.,  
Sec. 4, lot 5;  
Sec. 9, lots 4, 9, and 10, and NE $\frac{1}{4}$ SE $\frac{1}{4}$ .

The area described contains 165.32 acres in Elmore County.

2. Public Land Order No. 2588, which withdrew public lands for the Bureau of Reclamation's Snake River Project, is hereby revoked insofar as it affects the following described lands:

#### Boise Meridian

T. 2 S., R. 4 E.,

Sec. 3, lots 2 to 4, inclusive, SW $\frac{1}{4}$ NE $\frac{1}{4}$ , S $\frac{1}{2}$ NW $\frac{1}{4}$  and E $\frac{1}{2}$ SE $\frac{1}{4}$ .

The area described contains 262.10 acres in Elmore County.

3. The Bureau of Land Management Order dated January 28, 1952, which withdrew public lands for the Bureau of Reclamation's Mountain Home Project, is hereby revoked insofar as it affects the following described lands:

#### Boise Meridian

T. 1 N., R. 1 W.,  
Sec. 1, SW $\frac{1}{4}$ ;  
Sec. 2, lot 1;  
Sec. 3, lots 2 to 4, inclusive;  
Sec. 4, lots 1 to 6, inclusive, SW $\frac{1}{4}$ NE $\frac{1}{4}$  and SE $\frac{1}{4}$ NW $\frac{1}{4}$ .  
T. 1 N., R. 1 E.,  
Sec. 6, lots 6 and 7, W $\frac{1}{2}$ E $\frac{1}{2}$ W $\frac{1}{2}$ SE $\frac{1}{4}$  and W $\frac{1}{2}$ W $\frac{1}{2}$ SE $\frac{1}{4}$ ;  
Sec. 27, W $\frac{1}{2}$ ;  
Sec. 35, S $\frac{1}{2}$ .  
T. 2 S., R. 4 E.,  
Sec. 11, SE $\frac{1}{4}$ ;  
Sec. 12, SE $\frac{1}{4}$ ;  
Sec. 13, N $\frac{1}{2}$ ;  
Sec. 14, NW $\frac{1}{4}$ ;  
Sec. 15, N $\frac{1}{2}$  and SE $\frac{1}{4}$ .  
T. 3 S., R. 4 E.,  
Sec. 1, lots 6 and 7, SW $\frac{1}{4}$ NE $\frac{1}{4}$  and W $\frac{1}{2}$ SE $\frac{1}{4}$ ;  
Sec. 12, lots 1 to 4, inclusive, W $\frac{1}{2}$ E $\frac{1}{2}$  and NW $\frac{1}{4}$ ;  
Sec. 13, NW $\frac{1}{4}$ NE $\frac{1}{4}$ .  
T. 1 S., R. 5 E.,  
Sec. 29, W $\frac{1}{2}$ SW $\frac{1}{4}$ ;  
Sec. 30, S $\frac{1}{2}$ SE $\frac{1}{4}$ ;  
Sec. 31, N $\frac{1}{2}$ SE $\frac{1}{4}$ ;  
Sec. 32, SW $\frac{1}{4}$ .  
T. 3 S., R. 5 E.,  
Sec. 7, lots 3 and 4.

The area described contains 4,094.75 acres in Ada and Elmore Counties.

The total areas described aggregate 4,522.17 acres in Ada and Elmore Counties.

4. At 9 a.m. on October 2, 1995, the lands described above will be opened to the operation of the public land laws generally, subject to valid existing rights, the provisions of existing withdrawals, other segregations of record, and the requirements of applicable law. All valid applications received at or prior to 9 a.m. on October 2, 1995, shall be considered as simultaneously filed at that time.

5. At 9 a.m. on October 2, 1995, the lands will be opened to location and entry under the United States mining laws, subject to valid existing rights, the provisions of existing withdrawals, other segregations of record, and the requirements of applicable law. Appropriation of any of the lands described in this order under the general mining laws prior to the date and time of restoration is unauthorized. Any such attempted appropriation, including attempted adverse possession are governed by State law where not in conflict with Federal law. The Bureau of